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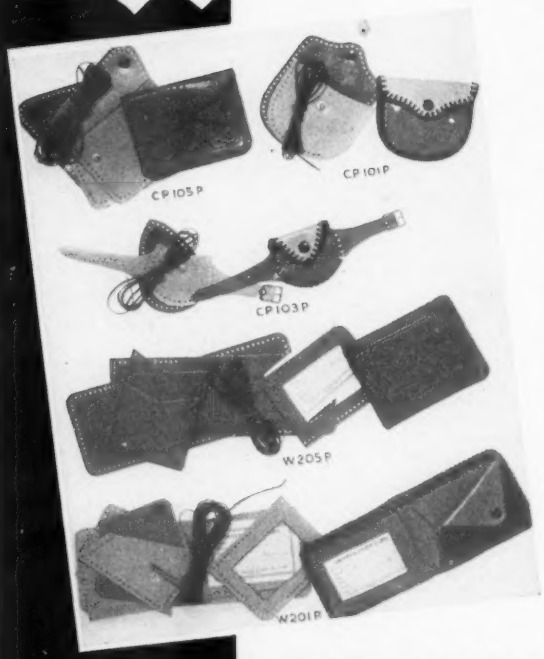

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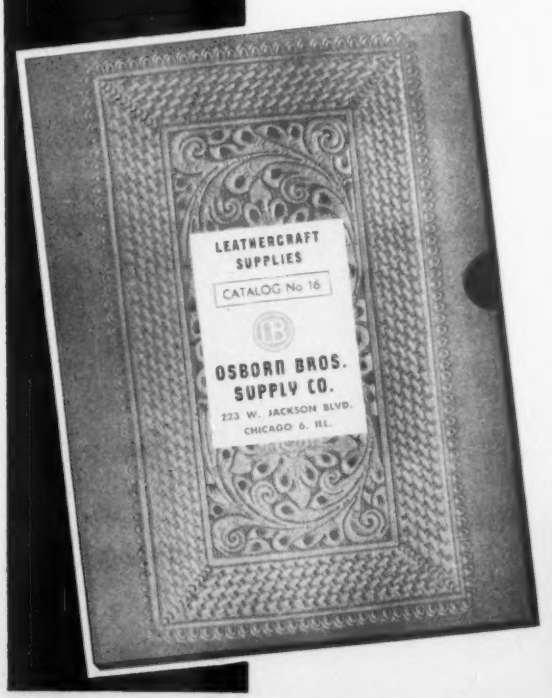

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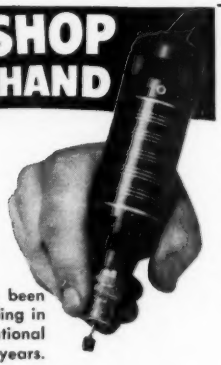

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Aphasia and Occupational Therapy*

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The failures of the language process due to injuries, neoplasms, developmental faults of the brain, and others, constitute serious obstacles to progress in all of the rehabilitative therapies.

Since the only contact between man and man is speech, the breaking of this bridge inhibits all education and re-education. In the aphasias difficulties are found in reading, writing, spelling, music, verbal speech, arithmetic, comprehension and gestural language, so that the therapist should be aware of the peculiarities to be found in the condition. It is not possible to teach handcrafts without a modicum of the give and take of language.

Unfortunately, aphasia today is in much the same position that the psychoses were at the turn of the century. Broad, general types of insanity were just being recognized, and the literature was full of new descriptions of bizarre symptomatology, each with its own Greek name. Modern psychiatry has been able to classify these groups of symptoms under general classes so that adequate treatment may be instituted. Aphasia, on the other hand, is still suffering from terminological and labelling problems.

Of course, the search for exact description of symptoms coupled with exact pathology is essential for medical and surgical treatment. From the standpoint of the occupational therapist, this detail is unnecessarily complex, and even from the approach of the logopedist it is more academic than realistic.

However, the modern speech clinic is able to study the problem of aphasia under certain empirical generalizations. This does require, nevertheless, that the therapist revise certain misconceptions of the functions of the brain, particularly the cortex, in order to understand what happens when areas are damaged or missing. First: the idea that the brain consists of a series of telephone circuits connected into a central switchboard is a completely erroneous analogy. There are no circuit breakers, no push-pull plugs in the brain, no telephone or dial operators. All synapses are open except while carrying, or having just carried nervous impulses. Second: the concept that learning occurs by traveling paths until they are worn ("the neurogram theory") is obviously absurd. Synapses are not "broken down" by repeated impulses, and the recovery which occurs after injuries to the brain is not the result of "opening new paths or detours". Third: the more modern notion of nervous impulses traveling by means of "neural loops" is a geometry of curves rather than straight lines, and is only the "path" or "neurogram" theory put in more complicated anatomical terms.

The brain appears to be a complex organ system, producing a series of fluxes of energy, coded to balance the ciphering system of the cranial and peripheral motor systems. When such a flux meets such a receiving detector, a reaction occurs.

What happens when a portion of the brain is injured? If the injury occurs in the left third frontal convolution of a right-handed individual, he will have a right, probably "spastic" hemiplegia, and ninety per cent of the time will be unable to speak. He is said to have a "Broca's aphasia", a "motor aphasia", or an "expressive aphasia". But close examination of this individual will always show some very bizarre peculiarities. Although this is supposed

This is the first of two articles written on Aphasia and Occupational Therapy by staff members of the Institute of Logopedics. The second article will appear in the July-August, 1950, issue.

to be a pure motor condition, with adequate comprehension, all such individuals suffer: 1. a minor diminution in general intelligence; 2. various types of perceptual distortions (visual, auditory, apperceptive, musical, agnosia, etc.,) of a minor sort of course, but present; 3. the possibility of *completely normal speech at any time,* provided the exogenous and endogenous patterns of energy vary in precisely the proper direction. This "normal" speech is both fleeting, usually only for a minute or two, and startling to the clinician; 4. a whole series of vasomotor symptoms, even though the lesion is unrelated anatomically directly to the controls of this system; 5. a picture of distorted affects and personality variants, and so forth.

If "Broca's area", therefore, is removed, is there a "loss" of the ability to produce articulatory stereotypes? No, not at all, even though they cannot be made by the case. Does the subtraction of this bit of tissue mean that some part of the language process has also been subtracted? Absolutely not. An illustration from algebra may help. The expression $x^2 + 2xy + y^2 = 0$ is a straight line. If one of the (x's) be removed from the squared term the equation will read: $x + 2xy + y^2=0$. This is a highly complicated function indeed compared with the linear character of the first expression. Yet all that has been done is to "remove", or "subtract" an exponent. Thus the subtraction of a bit of tissue from the cortex is always accompanied with fairly predictable effects —but not those of simple subtraction.

Also, it should be noted that the ability to "talk" is not located in "Broca's area". When this is removed, the remainder of the brain is still functional and functioning. The other neural processes and synapses which have shared in the process still "remember". All that is gone is the contribution of energy from this area, which enabled verbal stereotypes to flow forth in keeping with the propositional intent of the individual. This was accomplished by means of energy patterns from this tissue as necessary. Obviously, if a similar pattern were to be produced *in any other area,* and contribute the same effect to the totality of the spectra, the case would talk again. It is fortunate that this is so, since the central nervous system does not regenerate, and of course, the older theories are completely pessimistic. Therefore, the loss of an anatomical center would mean loss of a specific function. The automatic recoveries of these cases even in large damages is sufficient evidence that this view is impractical, and inconceivable in modern science.

Aphasia, then, may be defined as a speech disorder occurring when most of the brain is intact, but has focal losses of tissue due to mal-developments, disease, injuries, vascular accidents, and others. The speech disorders of aphasia ramify in a thousand directions. Speech itself is a complex cycling arrangement of signal systems between two or more individuals either figuratively or actually in contact. Both the output and the input systems may be affected in the "simpler" forms. That is, the production of articulatory stereotypes may be impossible under certain circumstances, or the comprehension may be impossible under other situations. From these more overt forms, very highly complex difficulties arise in personality, emotional behavior, "intellectual" activities, perception, apperception or cognition, all of which are language functions, of course. These disturbances may affect gestural concepts, such as writting, spelling, arithmetic, as well as the purely oral aspects of speech behavior.

This description seems to make aphasia a rather heterogeneous collection of aberrant phenomena. Since speech happens to be the most complicated function of the human, naturally its disorders are complex. Actually however, aphasias may be recognized as distinct from other disorders of speech by certain characteristics of language behavior that are common to all of the aphasias:

First: aphasia is a *propositional* disorder. Here it is very much like cerebral palsy and stuttering. The propositionality of a language situation is relative in character, and varies from individual to individual, from day to day, and from situation to situation, apparently being related closely to the physical habitus, the state of health, and the innate space-time reference frame of learning of the individual. A situation of extremely high propositionality for one individual may be of comparatively low order for the next, and what appear to be analogous situations following in time closely for the same individual may vary widely for him. For example, weaving through a wheel loom with blue yarn might be a situation of very low propositional order for a particular aphasic. A change to red yarn might be accompanied in the next moment with a propositional situation of such high order that language reactions would be impossible. These effects are predictable only in a very limited way at the present time, but all clinicians must be aware of them. Roughly, propositionality becomes of a higher order, requires more cortical tissue to surmount, as the demand for a language reaction places more and more premium upon a new integration by an individual directly to another individual. An over-simplified example might be the difference between a case saying the days of the week (a series sequence of relatively low order), and asking him to tell what day tomorrow is (a series sequence of moderate difficulty), or asking him to say what day it rained last week (a series sequence of relatively higher order). Of very high order relatively would be the voluntary statement by the case that his wife is to visit him next Monday. The over-simplification lies in the description of the disorder itself as a purely verbal one, and the fact that in some cases, this order

is *not correct.*

Second: aphasia is characterised by *perseveration* phenomena. Perseveration occurs when: A. the prepositional demands of a situation reach a level critically close to failure, and B. a choice reaction is demanded which occurs too close to the critical level. While the latter is propositional in nature also, what is referred to here primarily is in the nature of a decisive reaction. For example, in weaving, heddle number 1 may be moved twice for the sake of the pattern, and then heddle number 2 is used. If the choice between 1 and 2 has been too close to the critical level for decisive reaction while moving heddle 1 each time (i.e., the case makes a successful reaction), when heddle number 2 is called for, the case will repeat, perhaps for a number of times, heddle number 1, until he is either stopped, or stops in a bewildered way because the weave is piling up on itself. Without understanding on the part of the clinician, such a case may be considered "unintelligent", or "very severe", or even "mentally unbalanced". What was wrong in the situation was placing this case at weaving at all without careful preparation.

It should also be remembered that this is not a heddle bar failure, or a failure to learn weaving. It actually is a language failure. The case introspects as follows "Which foot? Which foot? Perhaps this one? Perhaps the other? Which foot?" A decision is made, but at the expense of a repeated and repeated reaction, which does not "make sense" to the observer. Many bizarre behavior patterns are due to a similar lack of choce, leading quite frequently to what may be called even "pseudo-psychotic reactions". It should be remembered, again, that it is not always the simple pattern the case can do well, and then fails on the "difficult". He may do a "difficult" pattern quite adequately, and fail on a very "simple" one.

Third: we are in complete agreement with Kurt Goldstein that *catastrophic reactions* are characteristic of all the aphasias. The catastrophic reaction is actually the perseveration phenomenon raised above the critical level until it becomes dangerous to clinical success, and *any perseveration phenomenon is a very serious danger signal.* It means that the critical language response ability of the case is in danger of being exceeded, and if it should be, all progress may stop, in all therapeutic departments, for days, weeks, months, or even permanently. The catastrophic reaction occurs when, A. a case is presented with a situation whose propositional level is so high that he cannot make an adequate response, but one in which the situation is such that he *must* make such a response. B. When a choice reaction is required which exceeds the critical language decisive ability of the case, but which he feels he *must* make. Obviously these two general situations are usually produced by the clinician, but they may occur through inadvertence on the part of nurses, parents or friends. When they are endogenous, the reaction appears to reduce itself fairly well. The catastrophic situation is marked physiologically by rather dramatic changes in the vasomotor system: Blushing, pallor, heart irregularities, alterations in blood pressure, temperature fluctuations, sweating, or reduction of sweating, temporary edemas in unrelated areas, temporary sensations of light, pain, heat, noise or anesthesia from kinesthesis. The case may appear simply fatigued. In any event, he will not only be unable to respond to the specific stimulus adequately, he may actually lose abilities previously recovered. This loss may dissipate in a few moments if the clinician is prepared, or may persist in an inability to learn anything at all for many weeks or months, or even, as mentioned, permanently.

Fourth: aphasias are definitely characterized by disorders in categorical behavior, and abstracting ability. As Goldstein shows, the Holmgren color yarns, in a case with color reaction aphasias (found in a majority of cases, regardless of type), are very clear examples of this behavior. When a typical case is handed the bright red sample yarn, and is requested to match it (naturally the word "red" is not used, since this is a test of language reactions) the red yarns are not selected at all, or if they are, they are selected in accordance with an aberrant pattern. Usually, the case selects all the bright blues, yellows, greens or purples. In other words he matches intensities, not colors. This is readily checked by giving the same case the pastel red sample. He now selects colors of low intensity. No case ever selects at random. Our studies on this problem with veterans are completely positive on this point, provided an aphasia was actually present. Only about one out of a thousand "normals" makes the same reaction. (True color-blindness in both groups is easily excluded by other tests). Why is this? The case simply cannot get the right category for his reaction. He sees the problem, makes an abstraction, (a perfectly logical one, by the way) but his categorical behavior is variant. This can be proved by simply asking the case (if his comprehension — language intake — is sufficient) to pick out the reds. He now acts as a normal.

Obviously, such behavior leads to bizarre behavior, perseveration phenomena or even castrophic reactions with a therapist naive in aphasia. Months of arduous work can be undone in five minutes.

Fifth: aphasias are frequently characterized by *a desire for spatial order and rigidity.* (Since space-time is a language function, some aphasics suffering disorders in this area do not show this sign). This need may be expressed overtly by re-arranging, for example, papers and books so that the arrangement of length and right angles is carefully patterned with the table on which they lie, or in an ambulant case

with rearrangement of the window curtains to exact heights, chairs in precise corners, or exactly parallel to the work-table, etc. This is not a neurosis, but appears to be a neuro-physiological means of reducing the propositional requirements of the environment. It can be shown that greater amounts of improvement can be obtained in aphasics by automatic attention to spatial orderliness. Since large amounts of materials and diverse equipment are always present in an occupational therapy department, it is essential that care be taken to arrange the items in spatial patterns. This can be done unobtrusively, without altering the essential rapport that such rooms should provide easily.

Sixth: the aphasias are commonly accompanied with *hyper-irritable attention.* Apperceptive centering has a very low threshold of stability, so that propositional sets are easily destroyed by changes in the sensory patterns of any sort, particularly light and sound, but also endogenous stimuli. This prevents the solution of problems well within the critical limits of the case, and retards general progress.

The terms "poor attention", and "distractability" have been used to express this phenomenon in cortical injuries, and are extremely misleading. A buffering and centering attack is indicated, rather than an attempt to increase the already over-active sensorium.

Seventh: emotional lability is frequently found. Uncontrollable laughter or tears, over-aggressive behavior, (or under-aggressive), socially unacceptable or awkward reactions, and similar gauches are found not only in the aphasias, but in some of the athetoses of cerebral palsy. The picture is distressing to friends and relatives of an adult case, who feel that he has "deteriorated", or is "not the person he used to be". In a child, the occurrence of the patterns from birth, or since an encephalitis, while also disturbing, is associated with the ego pattern. Actually, the personality of the adult is as formerly. He is often immensely upset at his own behavior, and does not understand it. What has happened is that the inhibitory areas, under propositional stresses, are unable to maintain poise and equilibrium. Fortunately, speech therapy technics are quite effective in non-psychotic cases, and, in fact, any clinical progress in any department with the consequent inhibitory gain over other integrations will be accompanied with some irradiation of inhibition. The reactions, however, should be understood as having very little "true" emotional value. They are simply a nuisance in the clinic, and must be dealt with. Also they do not accurately reflect the "intellectual judgment" of the case.

Eighth: in all of the aphasias, there is *initiatory delay and confusion.* This particular variant explains much of the pathological difficulties in the literature. For example, it is possible to have almost complete motor losses in aphasia without lesions in the motor areas. Loss of certain portions of the occipital lobe will so reduce the visual areas essential for "remembering" motor orientations that speech may be next to impossible to commence. In clinical work with all aphasics there is a persistent subjective impression that if only a few minutes more could be given to the case results could be obtained. Catastrophic reactions occur readily during the delay. It is probable that this picture is quite similar to other categorical losses, and consists primarily of a categorical disturbance on the output side.

Ninth: apraxias and agnosias exist in almost every case. These are so prevalent that they are almost definitive. The apraxias are defined as disabilities in conducting various complex motor skills on a propositional level which occur normally and readily when done involuntarily. Thus a case who cannot open his mouth, does so easily when a spoon is pushed quickly toward him. The agnosias consist of variations of a similar sort in the sensory field. Thus a case who was an artist draws beautifully, but cannot tell what he has drawn, or recognize any object from pictures.

Tenth: *persistent vasomotor anomalies* are always present so long as disordered function occurs. For example, if an arm is hemiplegic, it can be shown that there may be edemas, that temperature difference and arterial expansion are all abnormal. These vasomotor signs are of course highly important for tracing the return of voluntary function. That is, return of function is always preceded by return of normal vasomotor controls. The vasomotor signs of catastrophic reactions are, of course, transient. These signs persist for long periods of time. Many fatigue reactions also occur.

Cases presenting various combinations of these signs are aphasic. They have speech disorders. They will, of course, require an expert in this field as well as occupational and physical therapy for adequate recovery.

Adult and childhood aphasia are not identical conditions. In the first place, adult aphasia usually occurs with a hemiplegia on the controlateral side. Childhood aphasia is only rarely hemiplegic. Secondly, in adult aphasia it can usually be shown that the adult is still intelligent. In childhood aphasia the amount of intellectual possibility is always in question. Thirdly, adult aphasia is often fragmented, and partially normal. Childhood aphasia is usually nearly complete. These differences are probably due to the superimposition of the lesion in the adult upon learned behavior. In the child, many probably compensate for small lesions, leaving only the more severe cases to be recognized as aphasic.

It is obvious that the occupational therapist who wishes to do an adequate piece of work in aphasia needs training in the disorder itself, since language is the basic tool for learning. The condition is recog-

(*Continued on page* 140)

What Every Physician Should Know About the Rehabilitation of the Crippled Child

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Twelve years ago I had the pleasure of visiting hospitals and schools for crippled children in Denmark. At that time the director of the Danish Society for Crippled Care, one of the oldest societies for the handicapped in Europe, was Mr. Paul Bruun-Rasmussen of Copenhagen. In discussing the Danish plan, he stated that there were three distinct parts in their program of equal importance, namely, medical care, education and job placement. He further said that if an organization working with the handicapped was not prepared to assume the responsibility for carrying out these three parts, it would be better in many ways if this organization did nothing for the handicapped. Being a physician and coming from a country in which this concept was in no way accepted, I doubted the correctness of this statement. I was then of the opinion that medical care was by far the most important part of all programs and should be given, irrespective of what later happened to the patient. During the intervening twelve years there have occurred many changes in my ideas of programs for crippled care, and I have come to the conclusion that this statement of Mr. Bruun-Rasmussen is correct, and that a plan for the total care of the patient (as exemplified in his Danish program) is the only right one. Until recently our medical schools have not taught this concept to either the under graduate or the post-graduate. Our medical societies have had very few discussions of the subject for the practitioners, but with programs of rehabilitation rapidly taking form all over the United States, demonstrating what can be done with the handicapped, the doctors are coming to realize more and more that medical care does not end with the treatment of the disease or injury and that it is their responsibility to see that their patients are placed back into society with the best possible economic and social adjustment. Furthermore, it is becoming more apparent that for the realization of the objective, a combined program is essential where the doctor is the leader of the therapeutic team of the nurse, the social worker, the occupational therapist, the physical therapist, the psychologist, the academic teacher, the vocational teacher, and many other related workers. Unless the rehabilitation of the crippled child is effected in this way, the end result cannot be what is desired, namely, a crippled child which has been placed back into the community "so trained that he can compete, not as a handicapped person, but . . . as a person who will have no fear and ask no favor, a person who will be able to earn his way both intellectually and materially with just as little allowance made for his particular handicap as possible".

What is the pattern of this rehabilitation for the crippled child? How can it be accomplished?

The rehabilitation of the crippled child starts with the medical and surgical care at the age he is taken to the physician. Every attempt possible then should be made to restore the physical defects of this child to the normal or as near normal as possible so that there will be a return to the maximum usefulness of all parts of the body. This is the work of the physician and in the case of most crippled children it is the work of the orthopaedic surgeon. Immediately following or accompanying the indicated medical and surgical care the next stage of the program for the rehabilitation of the crippled child is divided into two divisions, namely, physical and mental. The physical division contains three parts: first is the physical conditioning, which includes group exercises and sports; second, there is physical therapy, which includes heat, massage, corrective exercises and a program of physical achievement tests or tests for the activities of daily living. These achievement tests are given to find out disabilities and abilities or what the extent of the handicap is and what the patient can do with his handicap. The carrying out of these is always an incentive for the child to do better the things he can do and do the things he cannot do. Third, there should be occupational therapy, which should be coordinated with physical therapy. It is not given for recreational purposes but as a therapeutic means of aiding in the restoration of normal function to a part. The second division is the mental. The mental division has academic education for all children, vocational education for the older children, that is those over 14 years of age and religious education. Teachers with special interest and training should be employed to obtain the best results. There should be a program which is the combination of the physical and mental, namely recreational therapy. This should include entertainment, such as plays, picnics, parties and movies, television shows, games, story telling, organizations and clubs for the children, such as Boy Scouts, Girl Scouts, and others.

The heads of the various departments who are responsible for the carrying out of these rehabilitation

(*Continued on page* 135)

Finger Painting Techniques at Ypsilanti State Hospital

Ruth Vogel, O.T.R., Carol Hanke, O.T.R.,
Harriet Miller, O.T.R., and Iris Smith, O.T.R.,
in Cooperation with Staff Psychiatrists,
Ypsilanti, Michigan

Finger painting has been used for some time at Ypsilanti State Hospital both as a diagnostic aid and as a therapy, by offering a means of free creative expression. Psychiatric interpretations were made in some cases, but it was felt that this interpretation could be facilitated by channeling patients' thinking toward significant symbols during the painting. Following interviews with the psychiatrist it became evident that patients' conflicts resolved about certain individuals either in the present or past environment. Using this information, finger paintings are prescribed designating certain "stimulus words". These words are either the names of individuals or specific relationships about which conflicts devolve. For example, a patient may be given the stimulus words, "mother", "father", "George", "voices". The initial painting is always a practice painting; the final one is the patients representation of himself. No suggestions other than these key words are given by the therapist. The results either correlate with the individual's expressed feelings toward these stimulus words, or exhibit his blocking. Sometimes the patient symbolically shows in the paintings what he is unable to say in interviews with the psychiatrist.

A systematized procedure has been set up and used by all therapists so that the method is as near standard as possible. However flexibility is required as it is not a true test situation and personalities are involved. Changes are frequently necessary as this use of finger painting is still in the experimental stages. A segregated room is prepared before the patient arrives, with the paints put in a central place, open and ready for use. Jars should be full so that the patient can use as much paint as he wants. A pan of luke warm water, pleasant to touch, is placed on the table. Any smooth-surfaced, washable table may be used. Depending on the size of the table, one or two patients may be placed together at one or at separate tables. It is advisable that a therapist supervise no more than two patients at a time. Having more than one, however, makes each patient feel more at ease. Aprons and rags are provided each patient. The papers are labeled on the back with the patient's name, the date, the number of the painting and the stimulus word. The paper is then wet and placed, glossy side up, before the patient. Chairs are pushed out of the way, so that the patient may stand while painting to have more freedom of motion; however, if he wishes to sit, he may.

The patient is asked to choose a color and place some paint of that color on the paper. He has free choice of all colors; red, yellow, blue, green, brown, black, and purple. It has been found that it is better to ask the patient to do the first painting in one color in order that he may get the feel of the paint and not be confused by colors; however, if a patient wishes to use two or more colors he may do so. He is told to put the paint on the paper, not to be afraid of getting it on the table or himself, as it washes off easily. He may be told that this is different than other painting in that it is done with the hands rather than brushes or other implements, and therefore is a freer media. The patient is asked to try different things with it, to paint whatever he wishes, although it need not be anything special. No further instructions are given. The patient is given freedom to do as he pleases. The paper is removed as soon as the patient indicates that he has completed the painting. All that he has drawn, said or done is later written in a descriptive note. The patient is asked to wash his hands before beginning each of the next paintings. If he persists in choosing one color it may be suggested that he can use other colors if he wishes.

If "mother" is the first stimulus word, the patient is told: "This painting is to represent your Mother. You may choose a color or group of colors that you would like to use." Often the patients say that they are not artists and cannot draw likenesses. It is explained to them that the technique does not require artistic ability. If the patient is extremely hesitant and puzzled he may be told that he might represent "mother" by something that reminds him of her, or tells in some way what she is like. No further suggestions are made. Should the therapist suggest an item or incident likely to remind a patient of his mother, she would possibly influence the patient's productions. If the patient is still hesitant the therapist may tell him to just choose a color, cover the paper with it and think of "mother" while working with the paint.

The third painting may be presented: "This is to represent your Father." The fourth: "This is to represent George;" and the fifth: "This painting is to

represent 'voices'." For an additional painting the patient is asked to represent himself. When a patient asks about the suggested words, for example, "What voices?" and if the prescription has not specified, the therapist can reply: "The voices you hear." The patients sometimes ask: "Have you read my record?" or "How did you get these names?" As much as possible these questions are evaded; however, it is sometimes necessary to explain to the patient that the doctor has asked that he do these paintings; that they are one of many methods the doctor uses to know and understand the patient better. Other problems that arise are handled as tactfully and impersonally as can be done so as not to influence the patient or his reaction to the word stimulus.

Soon after a finger painting session, complete notes are written. Each painting is described from beginning to end, what the patient said, what order he followed in painting, what color he chose, what he rubbed out, how much time he spent, what comments he made on the results, what questions he asked and the replies that were given. The painting is described so that the note will give the complete picture of what occurred at the session, in so far as possible. The patient is not questioned by the therapist as to why he drew what he drew, or what the objects are supposed to be. If she guesses what an object is and asks the patient about it, she may be suggesting something to him that he had not thought or planned.

If the methods described above are carefully followed by all therapists standard results can be obtained and the doctors prescribing the program can interpret the patient's reactions. This is very important if the paintings are to be regarded by the physicians as true diagnostic aids.

It has been found that interpretation of finger paintings is usually attainable if enough is known about the psychodynamics of the patient involved. They are useful in many ways not only diagnostically, but also in giving the psychiatrist an idea of the effect attached to the individual situation about which the patient has painted. Occasionally it is possible for the psychiatrist to make the diagnosis and to postulate the dynamics behind a case on the basis of finger paintings alone, without any clinical contact with the patient, but it is invariably necessary to have the patient's psychiatric picture to make a satisfactory and accurate interpretation of the finger paintings.

Much of the material painted is symbolic in nature and is often quite obvious to the psychiatrist. Parts lacking from figures are significant. These may represent either blocking, or castration, as in the case of the girl who represented her "boy friend" as a clock minus the hands. Blocking is also evidenced by very complicated, apparently meaningless figures covering the paper completely, with no objects depicted, or by leaving large spaces uncovered. A peculiar stippling effect which is made by patting the paper with one finger is usually diagnostic of paranoid ideation. This may not show in all the paintings of an individual, but is almost invariably found in the representation of the individual about whom paranoid ideation is present. The color is very significant: black, purple, and blue are considered as depressive colors. There has been a high correlation between the use of these and the patient's clinical picture. Yellow has been used almost invariably to indicate scorn, hatred, hostility and depreciation. Red or pink is largely indicative of high effective components. Brown is usually considered warm and is often used in depicting love objects. Green is considered a rather fertile color, the exact significance of which has not been worked out. As for specific symbolisms, the picture of a sea, lake or water line is invariably a feminine symbol. Trees may be either masculine or feminine, but most often are feminine symbols. Automobiles, horses, airplanes, and guns are usually phallic symbols, and often used to represent male figures. In individuals with homosexual conflicts, it has been found that phallic symbols are used to represent females, and feminine symbols, such as boxes, houses, barns, churches are used to represent a male figure.

With a few patients, finger paintings have been used therapeutically. The patient paints a series of paintings freely, without any stimulus words being given. The paintings are then taken to the psychiatrist, and the patient associates this material. This has not been widely used at Ypsilanti State Hospital, but in the few cases where it has been used, it would appear to be of value. The main difficulty encountered with the use of finger paintings is the fact that the psychiatrists and others have a tendency to project and to read into the paintings things which do not exist in reality, or things which the patient did not mean.

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Don't Forget

Glenwood Springs, Colorado, October 17, 18, 19, 1950

The Semantic Reactions of the Adult Cerebral Palsied

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The entire field of occupational therapy has been revolutionized during the last twenty years. When, after World War I, it emerged as an infant profession, its purpose was seemingly clear and simple. First and foremost, it was a temporary "mind occupier," and an activity to bolster the morale of persons who were invalided for relatively long periods of time. Essentially this was its foundation in psychiatry and among the blind, the tubercular, and the orthopedic. This foundation was gradually broadened, especially in traumatic and orthopedic cases, to include the functional restorative values so integrated today in occupational therapy. However, this history and growth of the profession is well known by any of its students. There is little need for its reiteration.

Within the past few years an entirely new aspect of this field has come to the fore. With the increase of demand for services among the cerebral palsied patients, the original purposes of manual activities lose value in the light of greater services. The occupational therapist is called upon to serve a severely handicapped individual who has been thus impaired since birth, to give him sufficient motor dexterity for feeding and self care, for vocational and social acumen—in short to equip him for normal living within the community. The occupational therapist now finds herself in the position of being a cosmetologist, a haberdasher, a job analysist, a fashion expert and a cross between Dale Carnegie, Elsa Maxwell and John Anthony. For this new role which is ever increasing, and to best serve these cases of all age groups from earliest childhood to chronological adulthood, there are certain basic concepts in human living and the psychology of these persons which are basic to her understanding of the total problem in perspective.

There is a law in biology which holds that no organism can survive without the ability to adjust itself to its physical environment. Thus man, as a member of the animal kingdom, cannot live a successful and happy life without the ability to adjust himself to his social environment. In dealing with the subject of the cerebral palsied adult, a physically gross deviant within the human race, one must consider some of the adjustments that the happy, self-supporting citizen within his home community, in spite of his severe multiple handicap, is called upon to make.

In recent years the problem of cerebral palsy has been given much more attention than in the past. For the first time workers in the various fields of rehabilitation have come to realize that the cerebral palsied individual can be made a self-supporting citizen with the opportunity to be happy. More and more effort is being expended in that direction. Techniques of surgery, psysical therapy, occupational therapy, drug therapy, and speech correction are being developed to aid these cases. However, man does not live by his physical abilities alone; he must also have attitudes and ideas which enable him to integrate himself into community life among his fellow men. All too often, this fact may be neglected by those interested in the rehabilitation of the cerebral palsied individual.

Dr. Martin F. Palmer, Director of the Institute of Logopedics, has observed that the goal of rehabilitation is to enable the individual to live as happy and as normal a life as possible. In order to accomplish this the cerebral palsied individual must learn to put the correct evaluation upon the attitudes and reactions his normal associates express toward him. In other words, one of his most urgent needs is psychological aid in adjusting himself to the particular situations in which he lives.

Much has been written about the psychology of the handicapped[1,3,9]. However, most studies of this nature are designed to measure deviations in intelligence and in personality of the handicapped person. These studies indicate that deviations in personality are present, but few of them point to the factors which cause these deviations.

The principles of general semantics as defined by Korzybski will be used as the basis for this discussion. General semantics itself has been described as the objective study of human response to speech and to other symbolic devices such as written language and facial expressions of emotion[6]. Korzybski hypothesizes that much of the difficulty which besets the human race is due to the fact that the language which men use does not fit the facts which they attempt to express[6]. In observing the relationship of the abnormal individual to the society in which he lives this seems to be true on sundry levels. The community tends to react to the abnormal individual in a sterotyped fashion. In turn, the individual himself reacts to the world about him in much the same manner. Factors which exist at one point in time are presumed to exist

throughout the course of time. The human fear of the unknown adds to the erection of a barrier between the individual and the world about him which is eventually cemented by mutual misunderstanding and even rejection, at times, to the detriment of both the individual and the community.

The semantic reaction of society to its deviant members has already been studied[2]. In that study it was pointed out that the total life situation of the individual could be represented by the following formula: B-F (PHxy). Such a formula has been employed by Kurt Lewin to represent the total behavior of the growing child[7]. In this discussion, the factors which make up this formula may be defined as follows: B equals the total behavior of the individual; F signifies the formula; P denotes the personality of the individual as determined by genetics and social factors; X represents the semantic reaction of the individual towards society and his own physical handicap; and H stands for the physical handicap present in the individual case.

It is to be noted that each of the factors represented in the formula may be broken down into many component parts. For example, P, the personality of the individual, may be approached from many viewpoints and may be divided into many different elements. Moreover, since personality is a verbal concept, it must be emphasized that its constituent elements are also verbal concepts. Thus, it seems that the total life situation of a handicapped individual is so great in its complexity that it defies any analysis. Attention will herein be focused upon what has been denoted as the "y" factor or the semantic reaction of the handicapped individual to society and to his own handicap. This is probably the most tangible factor in the total formula. It is clinically far more simple to work with the individual than it is to attempt to alter the total communal structure. And since adjustment of any one factor in the formula contributes to the better balance of the total formula, for clinical purposes this thesis has practicality to any study of the problem.

To aid in understanding the reaction of the handicapped person to himself to society, it might be well to review the main principles of general semantics, the tenets of which may be enumerated and defined as follows:

> The concept of *non-identity* focuses attention upon the fact that when he talks about the physical world about him and the psychological world within him, man really creates a third world—the world of words. Because he cannot express perfectly the world he sees about him or emotions that he feels within him, this world of words is similar to the world of reality but not identical with it. This difference between language and reality has far-reaching effects upon human relations".
>
> The concept of *non-allness* epitomizes the fact man cannot perceive the whole of the world about him or express in language all of the world that he does perceive. It follows that what man is able to express about the physical world and about himself is only an abstract from reality. And because in everyday intercourse man finds it necessary to make abstracts about abstracts, he drifts further and further away from concrete reality. Korzybski terms this continual process of abstracting reality "self-reflexiveness."
>
> The semantic concept of *time-binding* stresses the fact that man learns both individually and collectively from past experience. The experiences and teachings of childhood mold the behavior of the grown man, and history shapes the destiny of nations.

When these basic concepts of general semantics are applied to the total life situation of the cerebral palsied adult, they bring to light many factors which influence his behavior and with which the clinician must deal if he is to help the adult or child—to achieve the maximum of adjustment and happiness. For example, the process of time-binding operates in the life of the cerebral palsied individual on many levels, both personal and impersonal. A study of the history of ideas concerning the handicapped discloses that society in the beginning rejected such individuals because they were considered to be either evil beings or the manifestation of the wrath of God against the sins of Man. The austere warning in the Book of Exodus that the sins of the father would be visited upon the children reinforced this idea[4]. In fact, the custom which forbade the handicapped person to appear before the open altar of God which was practiced in the ancient Hebrew religion was simply a formulation in print of the fear of the unknown so prevalent among the unlettered, but it did much to reinforce and perpetuate this idea[5]. Thus, even today, lepers are still segregated from the community despite the scientific fact that leprosy is not as contagious as some other diseases. And, because of this idea that the abnormality is a manifestation of evil and sin, families throughout the ages have been ashamed of children who exhibit congenital variations from the expected normal. This is to be seen over and over again in the behavior and the attitude of families of many cerebral palsied individuals. In fact, it is one of the principle factors contributing to the lack of progress and scientific knowledge and rehabilitation in this area.

The process of time-binding has been evident on the scientific level because someone was once thought to have said that the cerebral palsied were feebleminded and therefore uneducable. During the past 100 years many such individuals have been committed to a life of vegetation in institutions for the feebleminded. This condition exists within our enlightened world of today and will continue to exist until public

education can overcome the effects of time-binding.

The process of time-binding also operates within the individual life of the cerebral palsied. The cerebral palsied person, although he has attained chronological adulthood, tends to maintain the position of the child in the family. During his early years, his physical limitations hinder him in learning to care for his own personal needs and wants. As time passes, two separate factors become evident. The first is that, despite the increase in motor capabilities, his parents or guardians seem content to continue to feed, dress and care for him on an infantile level instead of allowing him to do these things for himself. No doubt this tendency is rooted in some psychological need of the parents, but their firm belief that the child needs throughout his life the same care and the same type of love that he received in infancy is an excellent example of time-binding. By the same token, the cerebral palsied adult resorts to the same emotional and psychological releases that he found to be successful during childhood—emotional immaturity, self-centeredness, and a lack of responsibility for his personal conduct. This is emphasized in the view that the handicap and not the personality is to blame for the individual's unhappiness. While it must be recognized that both these manifestations of time-binding frequently occur among the average population, this fact does not subtract from their clinical importance in the problem of integrating the deviant individual into the community.

Another manifestation of parental time-binding manifests itself in the sheltered existence which the parent seeks to maintain for his disabled child. The child is carefully sheltered from the untoward reaction of outsiders toward his handicap and from the realities of life which he must eventually face. Here, again, time-binding operates on two different levels. The child himself, despite frequent verbalizing to the contrary, seems to enjoy this privileged type of existence and expect the same consideration from society as he is accorded by his family. Admittedly, the physical limitations themselves seem to present hardships which are not apparent in integrating the average human being into society. But in attempting to meet these frustrations and hardships which are seemingly enforced by his handicap, the cerebral palsied individual tends to develop certain reactions which for a time may serve as practical psychological means for attaining his goal but which after a period become outmoded because the needs they served are no longer present. Yet he continues in his practices of these attitudes much like the punch-drunk pugilist shadow-boxes. Thus, the cerebral palsied adult who knows that he excels in one area of human endeavor still has an over-emotional reaction to any correction of a mistake in that area, because he regards himself as a handicapped person who must continually prove to the world that he is capable instead of looking upon himself as a human being who, like fellows of his species, can err.

In the same manner, the phenomenon of non-identity operates in the life of the cerebral palsied adult in the same way as to make it impossible for him to identify himself with his able-bodied fellows or even with others who have different physical disabilities. Again, this is a bi-level process. It reacts both ways. Since cerebral palsy has been in the hall closet of the scientific world for so long, there may be some explanation of why the cerebral palsied individual may feel unique within society. It must always be remembered that the individual, regardless of race, creed or physical limitations, is essentially a human being. As a human being, there are more similarities than differences between him and his fellow men. Yet the growth of special schools, special therapies, and special specialists in this field, although necessary, gives emphasis and longevity to this feeling of uniqueness. Somewhere in the course of this training program the reality of the cerebral palsied as a human being, as the future citizen of a democratic community, must be faced. He must be trained to so regard himself. He must be taught to see that while his physical limitations prevent the realization of his dreams, social and financial reverses, and other circumstances also block the realization of similar dreams of others. The lack of identification with his fellow men, his own categorizing of himself as a unique being in the universe and even as a pariah in society, goes further toward emphasizing his differences from others than any other single factor.

On the other hand, society's reaction to the cerebral palsied may be typed as mal-identity rather than non-identity. Most able-bodied persons who know cerebral palsied adults or who have worked with them actually attempt to place themselves in the position of these individuals. The reaction of "What would I do if—" is extremely common. There is, however, one fallacy. The non-cerebral palsied person has a greater realization of what the individual is missing than the cerebral palsied person himself, and at the same time, he has less of a realization of what it actually means to live twenty-four hours a day all the days of one's life with a multiple physical handicap. Thus, the individual who dreams or imagines certain future incidents which never occur loses much less than the person who has briefly experienced such incidents, then lost them. One may dream of fame, but how much greater is the loss when dishonor follows a period of prestige?

On the other hand, those interested in the rehabilitation of the cerebral palsied adult daily experience the phenomenon known as "lack of carry-over." Certain therapeutic progress is achieved on a clinical level but is not evident in the daily life of the individual. It is difficult for the able-bodied to understand the reason for this fact. Descriptive phrases such as "lack

of insight," "too old for rehabilitation," "lack of interest," have been ascribed as causes. It seems incomprehensible to the professional worker, who feels that if he had this disability he would do everything within his power as quickly as possible to minimize it, that the cerebral palsied adult does not react that way. The cerebral palsied individual himself often does not understand why he fails to achieve carry-over, why he minimizes practice sessions and other efforts of his own to gain improvement. Actually, the reason is psychologically simple.

Improvement for improvement's sake ceases to become meaningful to the individual who lives his entire life with a multiple handicap and becomes absorbed in the incidental problems of living. The individual is more concerned with the experiences and lack of experiences in his narrow world than he is in the causative factors which underly these experiences or lack thereof. The ambulatory cerebral palsied adult is therefore more concerned with his lack of dates than he is with the appearance he presents in walking down the street. As long as he can get where he wants to go, he cannot see by himself that his lack of normal social experiences may be due to an unwillingness on the part of another person to share in the adverse attention he gets when he walks down the street. It therefore seems evident that the relationship of the two must be more concretely brought into focus. Psychologically, this is called the motivation. The absence of earthy, short-term motivation in the rehabilitation of the cerebral palsied adult, although it is oft times practiced in the training of the cerebral palsied child, is evidence of the concept of non-identity in those working on the adult level.

The third concept of general semantics, non-allness, manifests itself in the personality of the cerebral palsied adult in numerous ways. Its etiology is understandable in the light of the fact that in the process of maturing the individual's environment has been limited by his physical handicap. Often he must spend most of his time at home while his normal contemporaries are going to school, to the playground, and to the movies. In adolescence he may be unable to take part in the social experiences which are a normal part of that period of life. Often he grows from childhood to manhood without the experience of having dates, going to parties and other social functions and getting acquainted with people outside of his immediate environment. This circumstance limits his outlook and his understanding of the normal world. It also deprives him of the opportunity to learn social graces which help him in living with other people. He is also deprived of the opportunity to gain an understanding of the give-and-take of normal living. Thus he often manifests a hypersensitivity to criticism. He fails to see that normal people have their problems in life. Thus it is that he lacks experience which would aid him in correctly evaluating all of the situations in which he finds himself.

Another fundamental concept of general semantics, that of abstraction and self-reflexiveness, also enters into the personality development of the cerebral palsied child and adult. By virtue of these processes the individual grasps only part of the reaction of others toward him. He, however, assumes that he correctly evaluates this reaction. He is apt to feel that society rejects him because of his physical handicap, when in reality it merely objects to some quirk in his personality which even a normal person would be expected to conquer if it were called to his attention. He also tends to generalize on the basis of minor happenings and to evaluate everything around him in the light of his own experience. Often, he seems to lack interest in the work about him. Again, this may be because he is so engressed with his own problems that he feels that the rest of the world is unimportant.

All the semantic factors which have been discussed have direct application to the treatment of cerebral palsy. It is, however, imperative that in the clinical situation each person who has this condition be considered as an individual. No formulas of techniques have been developed which can be used on all cases with the same result. It was with this in mind that Dr. Martin F. Palmer remarked that the work in this area is "a creative adventure[8]." In speaking further about the clinical application, Dr. Palmer has also stated that anything which is done for the cerebral palsied individual tends to improve his physical condition .It is submitted that, in dealing with the cerebral palsied adolescents and adults who are confronted with many psychological problems extraneous to the physical condition per se, but affecting the appearance the individual makes to the world about him, meeting these problems on their own level will have a direct effect on the physical condition. Dr. Wendell Johnson has described the psychology of the handicapped as a "psychology of frustration and insecurity." He himself approaches the problem of stuttering by utilizing the basic precepts of general semantics, believing that the condition will be alleviated if the individual can be brought to a correct evaluation of his problem. This evaluation, according to Johnson, is the realization that stuttering does not set the individual apart from his fellow men and that the individual must not make the condition the center of his life. An attempt has herein been made to similarly evaluate the problems in daily living faced by the cerebral palsied adult. The psychological problems which have been described have their origin in the evaluation which the individual places upon his own life experiences. The physical side of cerebral palsy arises from injuries to, or maldevelopment in, the central nervous system. Its psychological aspect comes, for the most part, from the evaluation which the individual puts upon his condition and upon the reactions of others

(*Continued on page* 135)

Workshop on Wheels

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Out of sheer desperation we two therapists* who work with the men's ward classes decided to design the ideal ward cart after much irritation and frustration caused by return trips to the O.T. department from the ward, by sticking doors and drawers, by excessive amounts of time necessary to check tool inventories, and after much wear and tear on the tools and even more on the therapists.

We put our heads together, drew up a list of our problems and sought ways of getting around the "lemon qualities" of the existing cart. Fortuitously we had in the hospital at the time a patient interested and apt in mechanical drawing. We explained our ideas to him and he drew them up. Using the preliminary drawings as a basis, we discussed our needs again and revised the original drawing. The final plates were then made and sent over to the hospital carpenter shop where a patient who is a skilled cabinet maker by trade, constructed the cart. When the cart was completed, it was painted rust and silver, colors which we thought would be probable masculine choices.

The cart has now been in use for a year and we are pleased to say that it is nearly ideal. It fills our needs, it is portable, carries a full complement of tools and materials, and is easily and quickly checked. New men patients seeing if for the first time are impressed by its excellent design and business-like organization.

It is natural, however, that were we to do it over again, certain things would be altered or added. The wheels would be larger to make the cart more easily propelled. A rubber bumper around the entire lower edge of the cart would prevent scraping against the walls, and handles would be set into doors and drawers instead of protruding.

Certain refinements have been added since the photographs were taken. Nail compartments have been made to fit the bottom racks of the swing doors. File shelves have been built into both inner compartments. Guard rails now extend five inches above the raised ridge to prevent flexible magazines from falling over the edge. The ridge at the other end has been hinged to make cleaning of the top of the cart easier.

A view by view description is given and reference to pictures and plate will be helpful in identifying the various features mentioned.

LEFT SIDE VIEW — closed and open (photographs Figure A and B).

Top of Cart: raised ridge to keep articles too cumbersome to be stored elsewhere. Higher ridge at left end to hold books in place. (Metal guide rails on each side added since photographs were made).

Left hand drawer: for plastic materials and supplies.

Top center drawer: for all small tools such as scissors, extra knives, liners, punches, snap sets, pliers, pen point holder, and glass plates. All articles are held in place by elastic bands and each article has a place labeled for it.

Bottom center drawer: writing paper, carbon paper, tracing paper.

Right hand drawer: leather, lacing, leather samples, patterns.

Left hand swing door: five racks holding tapes, pins, paints, cleansing tissue, celluloid, pencils, erasers, spatter guns, threads, mucilage, labels, correction fluid, padding, glues, water colors, pastels, poster paints. All racks have plates with a label of contents.

Right hand swing door: plastic lacing, crayons, rulers, linoleum blocks, inks, nails. Individual nail boxes not shown in pictures or plate have since been made.

Left inner compartment: all tool positions shadow painted and tool clips screwed in place. Tools include screw drivers, hammers, coping saws, C-clamps, drills, drill bits, file cards. Vices rest on floor of cart. A file shelf not shown in picture was built in later in both left and right inner compartments.

Right inner compartment: also shadow painted and with clips. Tools include saw, hack saw, tin shears, wrench, squares, brace, leather mallet, planes, files.

Paper compartment: houses large pieces of bristol board, cardboard and drawing paper. Opens from both sides.

RIGHT SIDE VIEW — twelve compartments with adjustable shelves for housing patients' projects. Closed and open (photographs Figures C and D).

Lower left hand drawer: for wood supplies and scrap wood.

Lower right hand drawer: metal lined paint drawer. Stores enamels, lacquers, varnishes and their thinners and cleaners.

Left and right ends: waste disposal bins. Can be easily removed by unscrewing thumb screws and lifting up. Chromium handles aid in propelling cart.

Note the jointed doors on the back compartments. Note also, how well typewriters fit on top of the cart.

We thought that with modification for individual departmental needs, the mens' ward cart might be of value to other occupational therapy departments. For that reason working plates are also pictured.

*Mrs. Pauline Zarne, O.T.R. and Mrs. Mildred Trabert, O.T.R.

Fig. A

Pictures to the left and below show the left side view of the cart in closed and open views.

Fig. B

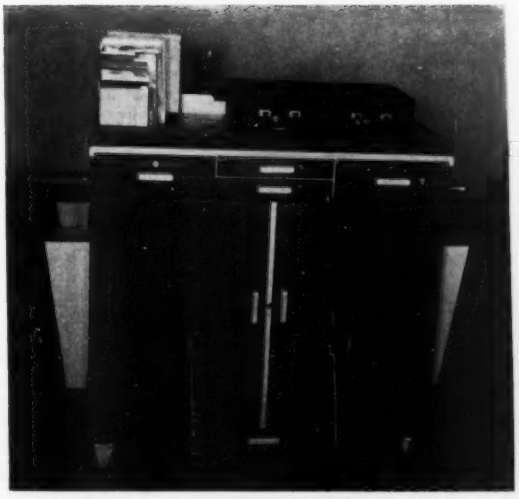
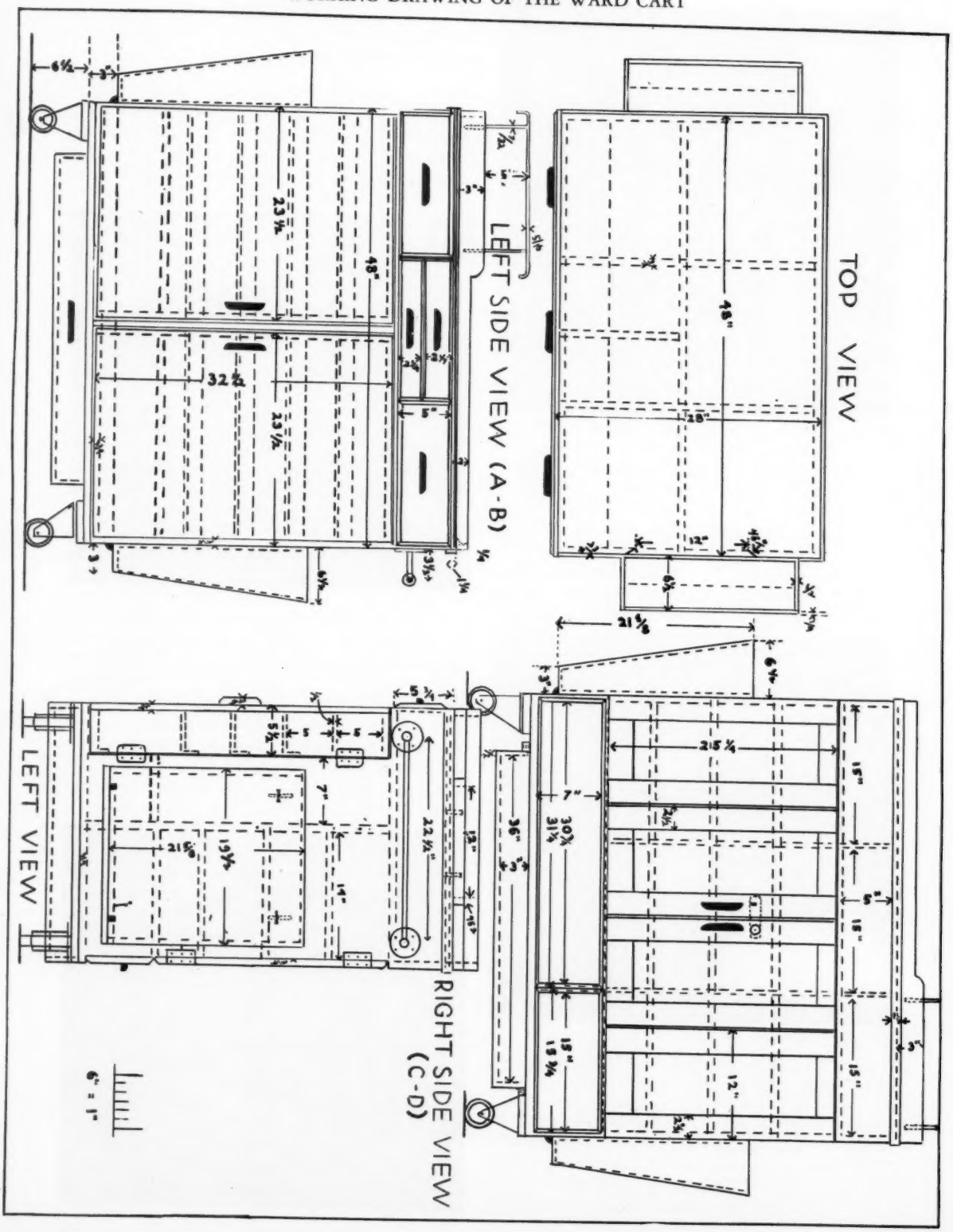


Fig. C

Pictures above and to the right show the right side view of the cart in closed and open view.

Fig. D

WORKING DRAWING OF THE WARD CART



Gardening as a Therapeutic Experience

Elizabeth Clarke
Baltimore, Md.

"Recreation has not only played an important part in the treatment program of many mental illnesses but it has been a considerable factor in enabling former patients to remain well."[1] The quotation from an article by William C. Menninger conveys an idea of the need of activity by mental patients in hospitals. There are many types of activities in which patients may become interested, perhaps one of the most profitable, yet relaxing and enjoyable to all those requiring physical exercise is that of gardening. The values derived from gardening, whether the participation is passive or very strenuous are far reaching, and give each person a chance to re-create and express himself. It may be a socialized activity or one where the patient is given an opportunity to advance according to his capabilities. The statement by Dr. Menninger can be applied not only to mental ills, but also to anyone needing hospitalization, and suffering a mental upset.

Gardening has an appeal for children as well as adults. They eagerly await the germination of seeds and watch with interest the development and growth of the flowers and vegetables. The large plant that grows from the tiny seed can be used as an introduction to arouse the interest of small children who later may be induced to attempt more difficult tasks. Children who are crippled, some that have never walked, venture on crutches to an adjoining greenhouse connected with the Hyde Memorial Home, Maine.[2] Supporting themselves against the benches they are able to work with plants, sowing seeds, transplanting and other operations necessary in growing flowers and vegetables. This is a way to have fun and incidentally learn to walk. For some children, it is the only means of getting them out of doors when there is snow on the ground.

The children not only supply the home with flowers during the winter but also take pride in the flower arrangements they make for the home—an ambitious project such as this requires a well equipped greenhouse, competent volunteers or a paid horticultural therapist and daily class work with the children. Interest may still be stimulated during the winter with less equipment by growing potted plants, making dish gardens and terrariums. Children never cease to enjoy watching narcissus bulbs growing or the sprouting of grapefruit seeds, the forcing of flowering shrub branches or watching the unfolding of the leaves on the tree twigs. When weather permits in the spring, starting gardens for flowers and vegetables prove a new wonderment, especially to the city child who never has experienced the joy of pulling radishes, particularly those that the child has had the satisfaction of growing.

Gardening for handicapped persons gives prescribed exercise while the patient is out-of-doors or in a sunfilled room. It stimulates the mind to pleasurable education leaving a permanent constructive value to the activity. Although some patients, because of their poor health, are not permitted to work out-of-doors it is possible to find many types of gardening in which to interest them either at their bedside or on a sun porch. An indirect approach is needed because the patient is confronted with the reality of a serious illness. When the necessary materials are assembled the patient confined to his bed may enjoy making a terrarium, either with rooted plant materials or with cut flowers from bouquets received at the hospital. These types of gardens afford the patient a means of expressing his artistic and creative ability and the cut flowers inserted in moist soil will be fresh for several days. Perhaps a gift plant can be used for propagation by the cutting of new plants for gifts to friends or other patients.

For the ambulatory patients plant propagation cases on the sun porch may be used to perform experiments to determine the best media for starting plants from stem or leaf cuttings, the best month of the year to take the cutting and which plants root more readily. The patient may be so interested that garden books will be consulted. Competition runs high to see who can grow the best plants from cuttings. Hydroponics can become engrossing, particularly to men interested in chemicals and the use of other elements that might speed plant growth.

In a New York hospital tubercular patients have formed an active garden club with presiding officers to officiate at monthly meetings to which guest speakers are invited. After the meeting a report is given in the monthly paper published by the patients. Timely flower shows and illustrated lectures vary the program. With the cooperation of the ambulatory patients, the ones needing bedrest may participate in the activities that are not over-taxing to their strength yet give them interest and hope to further enjoyment as soon as their health permits. Gardening in its very limited sense is purposeful in stimulating mental activity toward the anticipated participation. It is helpful in the harmonious adaptation to the environment.

Perhaps one of the most rewarding types of garden therapy is the work with the blind. The worker is rewarded by noting the change of attitude and the pure enjoyment experienced by the handicapped

when a new world of activity and usefulness is opened before him. The recent invention of garden tools especially designed for the blind[3] has been to a large extent responsible for the quicker and more complete recovery of some of the patients facing not only a new world of darkness but also the mental insecurity that frequently accompanies such a handicap.

As an introduction to gardening the patient may be induced to feel along the row of beets in order to pull out those that are crowding and preventing the growth of the other plants. By careful touch weeds may be distinguished from the vegetable in the row. The texture of leaves is a means of distinguishing between different vegetables, and the odor of others is characteristic. Cultivation of the soil between the row is aided by the special tools that Dr. Findlay has designed. The feel of the size, shape, and the odor of the flower and that of the foliage are distinguishing factors that assist the patient to become proficient in growing flowers for market or enable him to be a helper in a greenhouse where he can pot plants and perform other daily tasks. In this way the patient may become self supporting and find many enjoyments that had never before been presented to him. The sounds of nature in the country will take on new meaning and because of the purposeful activity the mind is not so confused and the patient leads a more normal life.

There are many therapeutic effects derived by working with soil. It is a treatment that is rewarded by the satisfaction of the accomplishment. Mrs. M. L. Price, of Shepphard Pratt Hospital points out interest in growing plants stands out as a fundamental drive. Even severe cases of mental illness may enjoy flowers and vegetable in the room or on the grounds of the hospital. Even among these patients an awareness and group interest can be obtained There is opportunity for simple and complex tasks as well as light and strenuous work. Energies of the over excitable patient can be utilized in this way. It is a constructive outlet for energy and hostility and improves the health of the patient through out-door exercise in the sun while improving the posture and appetite. It is a productive stepping stone to a more normal life. Gardening with its wide variety of creative problems is diverse and may fit individual needs depending on physical capacity, intellectual level and the emotional state.

As in most every undertaking, there are pitfalls that must be carefully guarded against. Miss Elizabeth Ridgway, occupational therapist of Delaware State Hospital, lists them as the misuse of tools, particularly the spading fork, rake and hoe, by the violent or suicidal patient. "Psychiatrists postulate the existence in the personality of an aggressive instinct which constantly seeks expression. Where its direct expression is denied, symptoms may develop. There are perhaps specific values in varying degrees and types of competitive activity."[1] The neuro-psychiatric patient will not be reminded of his failures if he has achieved a few successes in easy gardening, and his new attitude may be an invitation to the other patients to work in the garden so they too may share in the successes produced by the project. Gardening terms are familiar to most everyone. Voluntarily doing useful things will develop a will to do. Horticulture in its many phases is a useful treatment but also it helps the patient to select a hobby.

Classes in flower arrangement, agriculture, lectures on soils and simplified tests of soils may be worked out. The more experimental part of horticulture may appeal to a few. Experiments are many and may be used to keep the patient up-to-date with the latest developments in the scientific world, keeping him apace with the world of reality. One example of this use is the many possibilities that may be derived from hydroponics and the useful experimental work with root growth hormones with relation to their importance to the commercial florist.[4]

Trips to greenhouses, parks and gardens where they may observe and compare the varieties and culture of flowers as well as the architectural layout, stimulate the desire to improve their work. It may create a hitherto unexpressed pride in the appearance of the hospital grounds. The care of house plants, their propagation by cuttings and layering, the organization of garden clubs, preparation of exhibits in local flower shows, the preparation of the hospital bulletin board notices, especially those pertaining to activities, articles of interest, clippings and photographs are group activities that may be undertaken depending on the capabilities of the individuals.

For the more advanced functional disorder the patient can be assigned a problem that will prevent day dreaming. Perhaps the study of methods of attracting birds or the study of the kinds of flowers needed in a garden to attract butterflies will be beneficial. To soothe the manic the rhythmic exercise of sifting soil may be the activity that slows the elation and tends to equalize the reactions of depression.

In every case the treatment must be selected to meet the needs and background of the patient. In presenting the project, tact and diplomacy must be employed. Wherever possible a weekly or monthly report of the attitude and efforts of the patient should be recorded.

The field of gardening is limitless and has an appeal for everyone. The problem lies in the presentation of the activity in the most entertaining and interesting way to arouse the patient to eager participation and enthusiastic persual of the challenge that it offers. It has possibilities for every type of patient from the physically handicapped to those with varying degrees of mental illnesses.

The therapeutic success of the garden or nature experience depends upon the management of the

(*Continued on page* 116)

NATIONALLY SPEAKING

From the President

The mid-year Board and Education meeting at French Lick Springs, Indiana, April 15-17, was attended by forty tireless, hard working, enthusiastic members.

A fine record of accomplishment during the last six months was presented by the Education Committee with its sub-committees on Schools and Curriculum and Clinical Training. You will be receiving detailed information on the various studies as soon as the reports of these groups may be published.

However, to highlight a few will prompt you to watch for them in subsequent issues of the Journal.

The revision of the "Essentials of an Acceptable Course in Occupational Therapy" has been completed by the American Medical Association after collaboration with your National Office and the Education Committee. A copy of the revised Essentials appears on page 125 so that you may familiarize yourself with them.

Three special courses have been proposed by the Education Committee to meet the need for certain groups with special qualifications who may wish to become registered occupational therapists.

The plan for these courses will be made available as soon as the schools can make the necessary arrangements. It is suggested that they be geographically located to serve the East, Middle West and West Coast areas. It is hoped that this program may be started this fall in order to meet the demand for those seeking the opportunity and thereby in some measure meet the need for occupational therapists in the field. If the courses are established in September of this year, it is felt they should be evaluated in 1951 to determine the advisability of continuation on the basis of merit and future need.

Things to look for in the near future and voted by your Board:

The Clinical Training Committee presented revisions of the Rater's Guide and the Clinical Training Report which show an exhaustive study of the originals. These will be put in use as soon as the material can be provided from the Education Office. A new and comprehensive *Student Manual for Clinical Training* has been prepared and will be issued when editing is completed.

The Manual on Establishment and Administration of Occupational Therapy Departments was presented by that Committee. It is a fine contribution and will be reviewed and edited for publication by a small committee working with the national office staff. This project represents a vast amount of effort and will be of much value to the younger therapists taking directorship positions.

The Manual on Adapted Equipment, which we have anticipated for some time but which has required careful study and much technical detail is now assured and should be forthcoming within a few months.

The need for a statement of policy on occupational therapy has been felt by many. Careful consideration of an official message which the Association and its members might use as interpretation in professional and allied relationships has been made. The following statement has been prepared by the Education Committee and we trust that it may prove useful for you. Mimeographed copies will be made available from the national office.

OCCUPATIONAL THERAPY is a professional service which uses purposeful activities to aid the patient in recovery from and/or adjustment to disease or injury. It is prescribed by the patient's physician and administered by the occupational therapists with consideration not only of the specific disability but also of the patient's physical, mental, emotional, social and economic needs.

Relationship with the Physician

In the fields of psychiatry, pediatrics, tuberculosis and other medical specialties it is essential that the patient's physician prescribe occupational therapy in relation to the total treatment program. In order to insure continued guidance it is necessary that there be frequent contact between the therapist and the physician.

The Education of the Occupational Therapist

The education of the occupational therapist has been determined by the demand of the various fields of medicine in which this service is needed. Balance in emphasis on the medical specialties must, therefore, be maintained.

The American Occupational Therapy Association Education Program

The American Occupational Therapy Association believes that its professional courses can be most effectively directed by qualified occupational therapists in accordance with the essentials established by the American Medical Association for acceptable schools of occupational therapy. Advisory committees made up of representatives of the medical and allied professional fields are invaluable to the administration of the educational program.

Registration

Professional registration is an integral part of the educational program and as such has been established and is maintained under the jurisdiction of the American Occupational Therapy Association.

Winifred C. Kahmann, O.T.R.
President

From the Executive Director

This is a year of intensive effort on the part of all O.T.'s to promote publicity and recruitment. Through the special new Association committee, formulated for this purpose at the 1949 annual meeting, you have heard or seen evidence on state and local levels of the work toward these ends. Many of you are participating in this program either as individuals or through your local groups. We thought you might be interested to know what activities are being carried on by the national office to further recruitment.

Three projects which have consumed much of our time and effort should reach completion this summer. These are: 1) a manual for vocational guidance counselors, 2) a new brochure—*So This is Occupational Therapy,* and 3) a general film strip on occupational therapy.

The first of these, the vocational guidance counselor's manual, should be the answer to one of our principal problems in recruitment—namely, the placing of complete and correct information about occupational therapy as a career and the pattern of prerequisite and professional education for it in the hands of guidance counselors throughout the country. There are two reasons why this material is urgently needed: first, because of the inadequacy of material currently available for their use; and secondly, because much of the information they now have is incorrect. Our responsibility, having recognized these faults, is to supply new material which will correct them.

The new manual is designed with both of these purposes in mind. It is developed on the basis of an outline prepared by the National Vocational Guidance Association for the writing of occupational monographs. The ten principal points to be included are:

I. Brief history of the occupation
II. Importance of the occupation and its relation to society
III. Definition and duties
IV. Numbers and kinds of workers engaged in occupation
V. Need for workers — trends
VI. Qualifications
VII. Educational preparation — prerequisite and professional
VIII. Salary and advancement
IX. Working hours
X. Description of existing professional associations and discussion of their aims and purposes

Each of these general headings is developed in detail with reference to the information needed by guidance personnel. When completed, the manual will also have sections devoted to similar discussions of physical therapy, speech therapy, and special education. It will thus constitute a vocational guidance handbook on several careers in rehabilitation. Edited by Mr. Eugene J. Taylor, consultant to the National Society for Crippled Children and Adults, it will be published and distributed by the National Society. Availability is currently anticipated for summer or early fall.

Our second project, the perennial brochure, is closely related to the first in that it concerns recruitment and public information. It is however directed to the general public and to those potential students who do not have the benefit of vocational counseling. Periodic publication of general information leaflets of this type is one of the standard duties and activities of the National Association. You may recall the 1948 issue of *Occupational Therapy — Pioneering Profession,* early 1949's new look through *A Career of Service in Occupationual Therapy* and, later last year, the most recent pamphlet *Service Through a Vocation — Occupational Therapy.*

In all of these publications, we have tried to present information about the profession and training required for it in capsular form. The briefest of details have been provided but, generally speaking, an effort has been made to answer the principal questions that are asked and to provide references for more complete information. You may recall that our last brochure asked and answered the following typical questions: 1) what is occupational therapy? 2) what are the opportunities? 3) what are the qualifications? 4) what is the training? and 5) where are the schools? All this (and pictures, too!) was contained in a small, six-page leaflet. Format, color and pictures have been the principal variations in each of the last three publications, while content has actually remained much the same.

In our next effort, scheduled for June release, content as well as media will be new. Essentially the same questions will be answered, but in greater detail and with attention to providing the more complete type of information sought by today's students and parents in considering a vocation. For example, a suggested pre-occupational therapy curriculum guide, a detailed list of the accredited schools (including cost, type and length of courses, entrance requirements, etc.) and other information about training will be included. Charts and maps of the present

distribution of the use of occupational therapy — geographic and by disability area — will help to orient the prospective student and a generous use of pictures and color should increase interest and readability. Tentative title: *So This Is Occupational Therapy.* Watch for it this summer and, as always, we hope you'll send for copies and help with distribution.

Our third major endeavor has been toward the production of film strips. The value and effect of visual aids in publicity and for teaching purposes are generally recognized and we are becoming increasingly aware of the need for such aids in occupational therapy.

The material for two film strips has been prepared and production of one started. The first of these will show the application of occupational therapy with various types of disabilities and through a wide range of media. It will, however, have a non-technical approach directed to the layman's level as a general orientation. As an economy measure, an accompanying script to be read simultaneously with the showing of the pictures will be used in place of captions. This combination of selected pictures and explanatory script will produce a film that can be shown not only by occupational therapists but also by those unfamiliar with the profession. Usage can thus be unlimited. Prints from the original film can be produced at minimal cost and distributed initially to occupational therapy schools, state associations, individual therapists, and subsequently to schools, junior colleges, and other likely recruitment centers.

A second film strip portraying the training of an occupational therapist is also in process. Even more than the first, this film should be a boon to recruitment. As now contemplated, it will follow the student from enrollment through graduation, showing science and medical courses taught, creative and manual skills learned and application of didactic knowledge in clinical training.

If these first two film strips prove successful and worthwhile, consideration will subsequently be given to the production of other visual aids for illustrative and teaching purposes. For example, the various disability areas in which the occupational therapist works would make excellent subject matter for more films on specific aspects of the field.

The foregoing is a summary of some of the publicity and recruitment activities of the National Office for the first half of our current fiscal year (September 1949 through February 1950). As further projects are developed, you will hear about them either through AJOT or the NEWSLETTER. Meanwhile, let's all put continued effort into this vitally important part of our national program.

Wilma L. West, O.T.R.
Executive Director

From the Educational Field Secretary

In the September-October 1941 issue of AJOT, Vol. III, No. 5, p. 251, your President announced, under "NATIONALLY SPEAKING", the three year grant secured by the American Occupational Therapy Association from the Grant Foundation. The grant was given for the construction of "tailor-made" measurements to be used in the selection of prospective occupational therapy students. This project had been chosen by the Grant Foundation from a total of three for which we had submitted proposals. As early as 1947, the Board had voted for its inclusion in the research program of the Education Office, but work on it had to be postponed until now because other projects have taken precedence.

When considering an applicant for training, the director of an occupational therapy course is usually concerned with obtaining information on the future student's health, character, academic ability, manual dexterity, personality and interests. There are other aspects of course which have to be investigated but the above are essential to success in the practice of occupational therapy. Information is usually assessed quite easily for the four mentioned first—by medical examination, character recommendations, reference to high school records and to the results of general learning ability and manual dexterity tests used extensively in most schools and colleges. It is when we come to appraise the personality and interests of the applicant that we seek some means of pinning down those particular aspects which contribute to occupational therapy performance. The development of student selection instruments has been undertaken because of this need for objectively evaluating these aspects of the potential trainee.

Work on the project was started in October 1949. The first part of it was completed by eight selected O.T.R.'s during a two-week period in the National Office under the direction of our research consultant, Dr. Brandt. Prior to their work there, the consultants had been given assignments to facilitate the actual construction of the tests. These consisted of the following: *First,* since it is believed that the basic background of a candidate, his participation in and his reactions to a particular environment have been instrumental in producing the behavior pattern he now exhibits, two consultants were asked to define and expand in detail the biographical aspects of a prospective, successful occupational therapist (pre-college level). *Second,* since the behavior pattern of an individual depends also on the emotional, social, physical and mental adjustments made, two consultants were asked to prepare detailed outlines for this area. *Third,* it is recognized in addition that interests, hobbies and utilization of leisure time are vital aspects of the individual's success and two consult-

ants were given the assignment of preparing lists of possibilities within these areas. *Fourth,* still another aspect which appeared to be worthy of exploration was that of comparing and contrasting activities and reactions to ancillary medical specialties — physical therapy, nursing, dietetics, and medical social service. It is believed that information on the first three will furnish us satisfactory clues to successful performance in a hospital environment while the fourth may give us the answer to why one chooses occupational therapy as against any of the given ancillary fields. All outlines, although applying to many groups, were to be specifically oriented to occupational therapy. They were to contain information on the essence of a successful occupational therapist's personality and interest, and thus provide the content for the statements (test items) to be written. In addition to preparing these outlines, the consultants were asked to read references and examine available commercial tests and inventories.

During the session in the National Office, the consultants first received an intensive, two-day orientation on the currently used self-reporting measurements and the techniques utilized in constructing such measurements. Emphasis was placed on the approach and technique to be employed in our study. This was followed by the group's review, consolidation and final revision of each of the outlines submitted for the four areas. Two full days were taken up with this task. Approximately one day was devoted to the various aspects of the try-outs of the tests, such as the selection of suitable "guinea pigs" and the development of a simple performance evaluation form for criterion use. Finally, the remaining nine days were distributed about equally between individual item-writing, individual review by the research psychologist and group review and approval of the items.

The five hundred written items which resulted from the work to date are designed to cover all points in the outlines considered essential in the performance of a successful occupational therapist. They are constructed both in the multiple-choice and self-reporting form. In some instances, the same material is covered by both types of items for cross validation purposes. The experimental test forms are to be administered to varying groups of occupational therapists who will be a representation of a sample of occupational therapists practicing in the different disability areas, in various departments, and who have definite lengths of service in the field. Each therapist's answers for each item will be analyzed for validation purposes. The items found to be valid and differentiating will be tried again on the most recent graduates practicing occupational therapy and on students in clinical training for further validation purposes. Simultaneously, various types of rating scales and instructions for administering the tests will be tried to determine which will assess the most pertinent information and be most practicable for our purposes. Having accomplished this and other validation processes as are necessary, the materials will be compiled and introduced in final form as selection procedures for occupational therapy students. At this point, further revisions may be found necessary, but it is expected that the process of perfecting the instruments will extend over a period of three years and that the forms will become an integral part of our student selection procedures at the end of five years.

All outlines and items were recently submitted to two consultant research psychologists for review as to effectiveness of approach and methods employed. These psychologists were selected on the recommendation of the American Psychological Association for their experience and reputation in the area of personality and interest test construction. Both expressed the opinion that the approach and methods we are employing incorporate the newest and most promising techniques in this field. They also indicated enthusiastic approval of our attempt to construct selection instruments for a specific professional personnel, a much needed contribution to the field of selection of professional personnel.

At present the items are being checked for adequacy of coverage in the four areas previously outlined. Format of the preliminary test forms and directions for their administration are also being developed. It is our intention to approach several hundred practicing O.T.R.'s with the request to take the tests in the near future. We shall be as appreciative of the cooperation of those who are chosen to help continue the project as we are of the contribution made by the original eight consultants who are responsible for its development to date.

Eva Otto, O.T.R.
Educational Field Secretary

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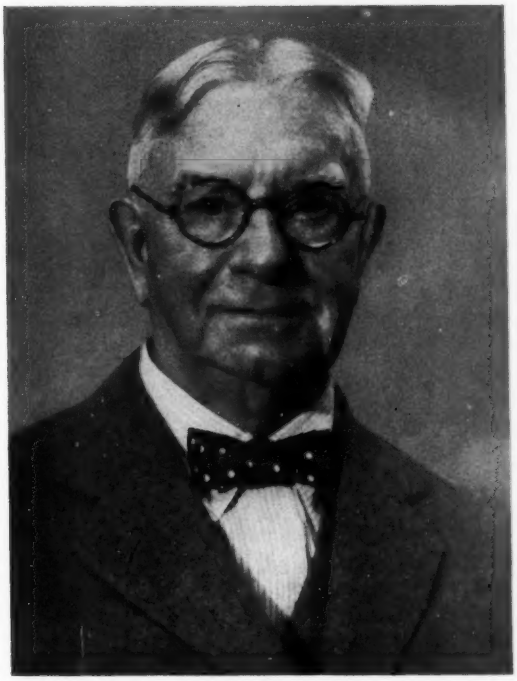

WILLIAM RUSH DUNTON, Jr., M. D., O.T.R.

A Biographical Sketch
by
SUE HURT GIBBS, O.T.R.

WHO'S WHO has a formal account of him, and anyone having access to O.T.&R., Volume 26, No. 1, can find on page 47 (according to Dr. Dunton) "all the scandal that's fit to print." One feels after reading Volume 26, No. 1 that if more of us had such "scandalous" pasts, the world would be a better and a happier place. However, those of us who have known Dr. Dunton for years need neither WHO'S WHO nor O.T.&R. to know this, and those of you who haven't, need only to look at his picture.

His activities have been, and still are, both numerous and varied — the activities of a man with a deep and vital interest in people, in medicine, and in creative ventures of all kinds. With this combination, there is small wonder that he has come to personify *occupational therapy.* We might try to choose the things about him that matter most to O.T. and O.T.'s, only to realize that it is he, himself, that matters, his variety of interests, his love of life and of the living, that have made him so vital a force in developing our profession.

He was one of that far-seeing small group of people who, in 1917, founded the National Society For The Promotion Of Occupational Therapy (later to become the American Occupational Therapy Association) in preparation for the inevitable entry of this country into the first World War. In 1922 he founded the bi-monthly journal *Archives Of Occupational Therapy* (changed later to *Occupational Therapy And Rehabilitation*) and was its editor until 1947 when the *American Journal Of Occupational Therapy* came on the scene. He is now Editor Emeritus of O.T.&R. and a member of the Advisory Committee of A.J.O.T. But even before this he was vocal in his belief in the therapy of occupations. His *Occupational Therapy, A Manual For Nurses,* was published in 1915 by W. B. Saunders Co., who also published his *Reconstruction Therapy* in 1919. Later, in 1928, his *Prescribing Occupational Therapy* was published by Charles C. Thomas (second revised edition 1945). (I might add that in the gay thirties, an O.T. student's education was not complete unless she had learned book-binding from one or all of these.) In 1936 he collaborated with John Eisele Davis in giving us *Principles And Practice Of Recreational Therapy For The Mentally Ill,* published by A. S. Barnes & Co. And now, scarcely off the press, comes another, *Occupational Therapy, Principles And Practice,* in collaboration with Sidney Licht M. D. and published by Charles C. Thomas. And in between these publications he has written articles far too numerous to list, which have been published in various journals. A bibliography of all his writings may be found in the aforementioned volume of O.T.&R.

But Dr. Dunton has not spent all of his time in writing. He has, in his own life, and in his medical ministrations, "practiced what he preached". He knows whereof he writes because he lives it. According to our *Year Book,* he was Medical Officer in charge of O.T. at Sheppard and Enoch Pratt Hospital, Towson, Maryland for thirty years, and O.T.&R. tells us that here he used early college experiences in dramatics and boyhood experiences with the printing press to promote these activities for his patients, and that he learned book-binding, leather tooling, basketry and other crafts so that he might use them therapeutically. After he became Medical Director of Harlem Lodge, his interest and efforts to promote therapeutic activities for his own patients and in the world in general, kept growing.

And all the while he has steadily pursued his own avocations. The one we know best is *quilts.* (Even this interest he came by in his attempt to supply satisfying occupations for his women patients.) The beautiful and valuable book *OLD QUILTS* which he published in 1946 bears eloquent evidence of the interest and enthusiasm that has gone into this for the

past thirty years. With the help of his son, Henry Hurd Dunton, an expert photographer, he hopes to complete a dictionary of names and designs, and already has over a thousand designs. Another avocation with which we are not so familiar is in the field of music. He was for some years drummer and tympanist with amateur orchestras, and was a member of the Johns Hopkins Orchestra until it was discontinued at the beginning of the second World War.

In a brief note in lieu of an interview preparatory to this article he writes: "I might add that at present my favorite smoking mixture is the same as that used by one of the present Smith Brothers, I forget which one, I think the serious one. But I'd evolved the formula before I read in the *New Yorker* that he used the same. Also at present I am curator for my wife's collection of book match covers which is getting to be quite large, due to kind friends who send us their used ones. (Kind reader take note). Mrs. D. and I have become scavengers and pick up what we can from sidewalks and even gutters, but do wash the latter to make them clean and neat."

Lest we omit matters of import: He was born in '68, received his B.S. Degree in '89 and his M.A. in '90 from Haverford College, and later was elected to the Haverford Chapter of Phi Beta Kappa. He received his M.D. in '93 from the University of Pennsylvania and has been a practicing psychiatrist and active in research and in the promotion of mental hygiene ever since. He is an Honorary Board Member and an Honorary Life Member of the American Occupational Therapy Association.

No Annual Meeting is complete without him. We can only hope that young occupational therapists attending their first conventions for years to come may have the privilege and the inspiration of seeing and meeting him there, as we have had for so many years gone by.

* * *

Gardening
(*Continued from page* 110)

project, and the interest and experience of the horticultural therapist.

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HELEN TOBISKA REA, O.T.R.

Biographical Sketch
by
Gayle Thelander, O.T.R.

Helen Tobiska Rea has been a very active member in the Colorado Occupational Therapy Association. This year, with the convention coming to Colorado, she has been selected program chairman. Helen is assistant-professor in charge of occupational therapy at Colorado A & M College. She came to Colorado A & M in 1946 to change a pre-professional course to an accredited course in occupational therapy. Although her school responsibilities have been large, she has always found time for professional activities. She has served as a board member, vice-president, and is now president of the Colorado Occupational Therapy Association.

In the beginning of Helen's professional work, she taught home economics, having graduated from Colorado A & M with a B.S. Degree. Later she turned to occupational therapy, and received her diploma from the St. Louis School of Occupational Therapy.

Her first job as a registered therapist was that of a staff therapist at Ypsilanti State Hospital, Ypsilanti, Michigan. Her next position was at Montifiore Hospital, New York City. Then in 1944 she joined the American Red Cross and worked as a hospital recreational worker overseas. In 1946 the hosiptal was closed, and she came to Colorado A & M in Fort Collins, Colorado.

The state of Colorado and our school of occupational therapy are very proud and very grateful for Helen Rea's efforts and accomplishments.

FEATURED O.T. DEPARTMENTS

CHILDREN'S HOSPITAL

Denver, Colorado

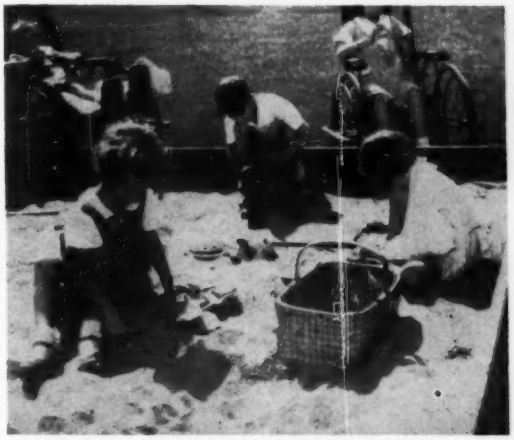
Anne R. Decker, O.T.R.
Director, Occupational Therapy

"For a Child's Sake" is the inscription over one of the entrances to the Children's Hospital in Denver, Colorado. The hospital is one of the specialized institutions in the country entirely devoted to the care of children embracing the services of pediatrics, orthopedics, and contagion. From the reception of its first patients on February 17, 1910, it has grown from a small residence property with slender equipment and the capacity limited to about 35 children to its present modern, well-planned construction, supplied with all necessary beneficial equipment, and has a 210 bed capacity. It is a private, non-profit organization serving Colorado and surrounding states. It includes all of the various services which contribute to the needs of total treatment of its patients. The age range includes children from birth to sixteen years.

The occupational therapy department is under the immediate direction of the director and medical director of the hospital. It is supported entirely by the hospital—salaries are paid and a yearly allotment is maintained for equipment and supplies. The staff consists of two registered therapists and a quota of four students receiving full maintenance.

Referrals for all hospital patients are made by staff or resident physicians and out-patient referrals are made by a physician through the cerebral palsy clinic. Information included on the referral sheets consists of case number, name of patient and physician, diagnosis, age, place of treatment, hours of daily activity, precautions to be taken and reason for treatment which is divided into functional treatment and psychological stimulus. This information is supplemented by the therapist making a study of each patient's hospital chart which is available to her at all times and by consultation with the doctor and charge nurse.

The program is divided into three services: the workshop program, the ward program, and the out-patient program. The physical aspect of the department consists of one workshop situated on the ground floor and just next to the elevator which facilitates convenient accessability to the hospital patients and out-patients alike. The shop is small but well equipped and supplied and can accommodate ambulatory, wheel chair, and perambulatory patients. Its limited size does curtail some of the potential activities; however, by space conservation and schedule arrangement, quite a complete and diversified program is made available to the patients.



Playground Activity

The workshop is open for hospital patients for an hour and a half mornings and afternoons Monday through Friday and Saturday mornings. Pediatric and orthopedic patients are sent to the workshop for a remedial or functional program. An effort is made to make the workshop a gay and interesting place so the children will enjoy being in it and will have a change from their wards with a complete absence of the usual hospital atmosphere. This gives the children an opportunity to work in a normal group situation from which much benefit is derived. It is gratifying to see a shy, homesick child blossom out into a happy personality through workshop contacts. Through the confidence gained and social contacts made with other children in a normal atmosphere, the child makes a better patient when on the ward. Activities used are varied and adapted to the pediatric aspects of occupational therapy. Medical and surgical patients: e.g., cardiacs, nephritics, post-appendectomies, are sent to the workshop when they are ready for a work tolerance program. Diabetics who are undertaking insulin regulation receive activity comparable to their normal activity capacity. Behavior problems of small children are observed in normal group activities. Such diagnoses as burn contractures, arthritis, convalescent poliomyelitis, and peripheral nerve injuries are referred for functional therapy and the general occupational therapy activities meeting the individual patient's needs are used. During the summer, a portion of the shop program can be transferred to the lovely yard, just outside the department, where the children not only participate in craft work and recreational activities but also reap the benefits of fresh air and sunshine.

The ward program covers two services: the general medical and surgical division and the orthopedic di-

vision. Patient contact is made simultaneously with the workshop program by individual therapists assigned to each service. On medical-surgical floor are found such diagnoses as rheumatic fever, chorea, nephritis, diabetes, URI'S blood dyscrasias, burns, appendicitis, brain tumors—in general, all pediatric conditions. The tonic aspects of occupational therapy are

Cerebral Palsy Pre-Feeding Treatment

utilized. The patient's need for help in adjusting to a new surrounding and situation and perhaps a long convalescent period is met. The activities used are selected with consideration of all ramifications of the patient's physical condition, age, interest, and length of hospitalization. On the orthopedic floor, convalescent poliomyelitis, post-polio orthopedic surgery, congenital dislocated hips, Perthes' Disease, fractures, osteomyelitis, idiopathic scolioses, tuberculosis of hip and spine are the diagnoses which make up the general case load. Here, besides the general tonic aspects of pediatric occupational therapy, are met the needs for special equipment adapted for patients in casts, frames, and traction, for help in maintaining motion and strength in uninjured parts and aiding circulation and nutrition to the disabled part and for aid in the adjustment and acceptance of a possible permanent disability.

The children keep the articles they make. If the therapist thinks it advisable, the children are able to earn a little money by making orders for the hospital personnel. This is not practiced to a great extent but on occasions has had a nice therapeutic value.

A portable record player has proved very beneficial in supplying a program of recorded music and stories to such cases as rheumatic fever and chorea when the patient is still on absolute bed rest and to the admission floor when the patient is making the first adjustment to hospitalization but due to the isolation techniques practices is not eligible for an occupational therapy referral.

The hospital is fortunate in having an active entertainment committee which arranges special entertainment for the children including moving pictures in the hospital auditorium every other Saturday and a variety of interesting programs. The committee members also arrange a very wonderful Christmas party for the children.

The library service is taken care of by the Junior League Volunteers. They take a book cart to the floors three times a week.

The cerebral palsy out-patient program is an entirely separate program. Since the occupational therapy department has just one room, it is used for the out-patients during the four hours daily when it is not open for hospital patients. Much of the same general equipment is used and there are also four especially adapted and adjustable tables and a relaxation chair for the cerebral palsied. These patients are referred directly through the weekly Saturday morning clinics held by the medical director of the cerebral palsy clinic. There are also weekly clinics with a staff of a pediatrician, orthopedist, neurologist, and psychiatrist available for consultation for any individual problems. The occupational therapists attend these clinics routinely.

These children come in for physical, speech, and occupational therapy either from their homes or from

Cerebral Palsy Self-Feeding Treatment

Boettcher School, a specialized school for handicapped children under the public school system. The school is situated just across the street from the hospital with a connecting tunnel. The children come to occupational therapy for regular half-hour treatments either daily, one, two, or three times a week for individual training directed toward coordinated activity. The many ramifications of the cerebral palsy problem are considered in the treatment. Adapted crafts and educational toys are utilized in treatment methods. Self-help activities are taught with stress placed upon

feeding and dressing. Self-feeding treatments are given using built-up spoons and plates and getting special trays from the diet kitchen of mashed potatoes, ground meat and mashed vegetables—these are replaced with regular vegetables as soon as the child has progressed to the point where he is able to manage them. In self-dressing, the Montessori type snap, button and tie boards precede the actual dressing processes which are introduced when sufficient progress has been made. Graphs are kept to show the patient's progress and these act, incidentally, as a stimulus to the patient.

The therapists work in close contact with the parents in the attempt to have a carry-over in treatment in the home. For the milder cases and for those living too far away to come in for regular treatments, a home program is set up for the parents. Progress is checked and further suggestions are given when the child returns for periodic clinic check-ups.

The occupational therapy department works in close relationship with the physical therapy and speech departments in this program. Staff meetings, consisting of the cerebral palsy medical director, physical, speech, and occupational therapists, and school principal, are held and each patient is discussed by each member. This is very beneficial in gaining full understanding of the patient's needs and enabling a maximum effect to be gained from all treatments.

The clinical training program offers students an opportunity to gain experience in all of the services in which the occupational therapy department has a part. They attend orthopedic and cerebral palsy clinics and observe in allied departments. Since Children's Hospital is a teaching center, the occupational therapy students are fortunate to be able to take lecture courses in medical-surgical pediatrics, child development, and orthopedics with the student nurses. Each senior nurse is assigned a three-day service in the occupational therapy department.

In view of the expansion of the program in occupational therapy since the department was started, the present workshop is too small to fill the needs of the hospital and to utilize the full potentialities of occupational therapy. It is hoped in the near future to have a larger department so more equipment can be added and recreational activities expanded; one that will have a separate room for the out-patient program so it can be carried on simultaneously with the hospital program.

SEE YOU IN COLORADO

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EDITORIAL

POLIO PREPAREDNESS

This is the time of the year it is necessary to prepare for the emergency of polio. Parents and community leaders are anxious to avoid the disease that is spreading and increasing each year.

As occupational therapists you are trained to work with polio patients after the acute period has subsided if the attending physician deems it necessary.

But are you also prepared to advise friends, relatives, parents and others if polio cases are diagnosed in the community and they are frightened, bewildered and dismayed? Panic can be avoided by a calm attitude among professional people.

The National Society for Infantile Paralysis has prepared directives which we should all read and memorize. Wise help and advice at the proper time will help the doctors, nurses and trained personnel during a critical period.

Keep children with their own friends. They should be kept away from people they have not been with right along, especially in close daily living. Many people have polio infection without showing signs of sickness. Without knowing it, they can pass the infection on to others.

Prevent over-tiredness from work, hard play or travel. Polio infection may already be in the body; being very tired may bring on serious polio.

Prevent chilling. Bathing or swimming in cold water should not be prolonged. Wet clothes should be taken off at once. Chilling lessens the body's protection against polio.

Keep clean. Hands should be washed carefully before eating and always after using the toilet. Hands may carry polio infection into the body through the mouth. Food should be kept clean and covered.

Watch for early signs of sickness. Polio starts in different ways — with headache, sore throat, upset stomach, sore muscles or fever. Persons coming down with polio may also feel nervous, cross or dizzy. They have trouble in swallowing or breathing. Often there is a stiff neck and back.

Call the doctor at once. QUICK ACTION MAY LESSEN CRIPPLING. Until he comes, the patient should be kept quiet and in bed, away from others. The patient should never know those attending him are worried. The doctor will know what to do. Usually polio patients are cared for in hospitals, but some with light attacks can be cared for at home.

Call the local chapter of the National Foundation for Infantile Paralysis if help is needed. (If the number is not in the telephone book, call the health department for the address.) Chapters are made up of people in the community, banded together to give help to polio patients. Polio is a very expensive disease to treat. *But no patient need go without care.* The family pays what it can afford, the chapter pays the rest of the cost of care. This help includes payment of hospital bills, nurses and physical therapists, transportation to and from hospitals or clinics, treatment after the patient leaves the hospital, wheelchairs and braces when needed. This is not a loan. The American people make these services possible by giving to the March of Dimes.

Remember—there is no "quick cure" for polio and no way as yet to prevent it. With good care, most people get well, but some must have treatment for a long time. Therefore advise others, "The more you know about polio, the less you fear. More than half of all people who get the disease recover completely without crippling. IF POLIO COMES, ACT QUICKLY. CALL YOUR DOCTOR. DO WHAT HE SAYS. ASK FOR HELP IF YOU NEED IT. YOUR NATIONAL FOUNDATION CHAPTER IS STANDING BY TO AID YOU."

Letters to the Editor

Dear Editor,

You have asked for something about my experience here in England. It is very different from that which we had in Czechoslovakia. Occupational therapy is developed much more fully here than there. The Association for Occupational Therapists since 1935, has done a great deal in bringing occupational therapy to the attention of the public, in establishing standards for schools, in conducting national examinations (the student goes through two lots here, preliminary and final), in establishing recommended wage scales and so on. Today it is carrying the responsibility for many of the adjustments that must take place in the new health scheme, a far from easy task.

Here in Liverpool there is a pioneer nature to the work that is rather challenging. The medical profession does not know occupational therapy as well as in the south. The starting of a new school under such circumstances has not been simple. The school is three and a half years old, has sent its first students up for their final examinations successfully and has been carrying out some theories of occupational therapy training which are a little different from the usual.

As vice-principal, my job includes some teaching at the school and some supervising in four hospitals. Of the two general hospital departments, one is run by an English therapist and the other by a Dane. A Canadian is running the geriatric department and

another English girl with the assistance of an Australian is running the tuberculosis sanatorium. Evelyn Swift, O.T.R. (Phila.), is in charge of one of the psychiatric departments and is doing a fine job there. I sometimes feel like a globe trotter listening to the ideas produced by such an international group. In passing I might add we have a student each from New Zealand, South Africa, Israel and one coming this month from Malaya. I am having a wonderful lesson in British geography, learning the places from which the British girls come, for they are by no means all from the Liverpool area.

Added to this we have had the excitement of sending off a group of occupational therapists to Germany last November, to work under I.R.O. in the D.P. hospitals of the American Zone. Mrs. Glyn Owens, O.T.R., the principal of the Liverpool School of Occupational Therapy was appointed consultant for I.R.O. following a survey which she made of the needs in the area. Ilse Heinemann, T.M.A.O.T., a Czechoslavakian by birth and now a British citizen, is in charge. Her skill with languages added to her ability in occupational therapy has been a great asset. Incidentally her main headquarters are near Lottie Blanton, O.T.R., in Munich. She has eight qualified and four unqualified assistants who are developing the work in general, psychiatric, and tuberculosis hospitals throughout the zone. We are hearing a combination of good as well as pretty grim reports as the work is getting under way.

In acquiring background for some of my teaching, I am having a liberal education in the rehabilitation services of this country. The centers visited so far have been very interesting, especially in the way they have been geared to the local industries of the community in which they are placed. Help given me by Almoners (social worker) and the D.R.O. (Disablement Resettlement Officer) have been most appreciated. Re-employ factories have been set up largely as sheltered workshops. Government retraining centers are preparing people for new employment and there is one home recently opened for badly handicapped paraplegics where a special arrangement has been made for them to spend the day in nearby industries. Some of this is very new and hence variation in service exists still but the goals are very complete.

There are some links between occupational therapy and rehabilitation. For example in a London hospital, one psychiatrist is having weekly conferences with the local D.R.O. regarding employment for his patients when they are discharged. On nearly half the patients, "an occupational therapist's report was available, and his opinion was valuable in assessing the patients' employability in ordinary life."

It has been a good experience being associated with Mrs. Owens. Since she has been one of the leaders of occupational therapy in England from the beginning, she is an authority on the subject. Along with this, she has always believed in maintaining links between her school and the United States. It has been fun to be a student of the English way of occupational therapy under her for this short year.

"Cheerio"

Lucy G. Morse, O.T.R.
Vice-principal
Liverpool School of Occupational Therapy

Dear Fellow Members of A.O.T.A.:

Early in 1949, A.O.T.A. received reports from the occupational therapy schools indicating that 600 vacancies were anticipated in the 1949-50 school year. This news caused deep concern at a time when demand for professionally trained workers was fast increasing, and it was known that desirable projects were being postponed or scaled down for lack of

Window Display, Enoch Pratt Free Library, Baltimore

suitable personnel. Authorities like Dr. Howard A. Rusk have estimated the need for registered occupational therapists in the thousands, while the annual net increase is reckoned in the hundreds.

Occupational therapy is thus confronted with a serious crisis. Unless the gap between the need for workers and the supply available can be closed, two undesirable consequences may well follow — either some present functions of the occupational therapist may be encroached upon by other professions, or else there may develop a tendency to fill O.T. titles with workers having sub-standard preparation.

As a first step in meeting this situation, A.O.T.A. has set up a national committee on recruitment and publicity, of which I have been appointed chairman. Last June a policy meeting attended by Miss West and representatives of the two O.T. schools in New

York, was held here. It was decided that first efforts should be concentrated on recruitment of students for career training, giving general publicity for occupational therapy an incidental status. A policy of working through the state O.T. Associations was laid down, but it was recognized that in states having no O.T. organization, individuals should be invited to undertake responsibility for recruitment. The appended roster will show that this appeal has generally been successful. Seventeen O.T.R.s have been found willing to render this service to their profession, without backing from any organized group.

It was also agreed that initial approach to recruitment should be through vocational guidance personnel, deans of men and women and other school officials responsible for counseling, by means of an informational canvass, material for which would be supplied through requisition by the National Office.

State Associations were asked to bear as large a portion of the cost of this canvass as they felt able to assume, but have been informed, through their chairmen, that A.O.T.A. would underwrite deficits incurred if funds available for the recruitment project became exhausted. Local chairmen in states having no organization, would, of course, look to A.O.T.A. for full reimbursement.

During the convention in Detroit, a meeting of the Recruitment Committee was held. At that time 33 states or regional recruitment chairmen had been obtained. Thirty-eight persons attended the meeting, which was open to all, and resulted in many valuable suggestions. Since last August our roster has increased to 45 names, and pretty well covers the nation, as some chairmen have generously agreed to be responsible for more than one state.

The mechanics of activity have developed along the following lines: each chairman has been instructed to form her own committee, not necessarily limiting membership to O.T.R.s, or even to practising occupational therapy workers. Some very successful committees report having members from religious, higher education, medical, teaching and business groups.

A policy of encouraging local committees to function autonomously, has been thought desirable, but has also been necessitated by the circumstances of distance and limited physical facilities. The following activities have, however, been recommended to local chairmen, as likely to prove effective: —

1. Informational canvasses of vocational guidance and other student counselors in the nation's high schools and colleges with two folders, *A Career Of Service In Occupational Therapy* and *Your Future In The Women's Medical Specialists Corps,* accompanied by a covering letter addressed to the vocational guidance counselor. Supplies of both these folders have been exhausted, but A.O.T.A. has brought out a new offering called *Service Through A Vocation,* while W.M.S.C. is understood to be about to release a new recruitment brochure.

   The above material, reprints of Dr. Rusk's article in the N. Y. Times of August 25, 1949, and other information suitable for recruitment purposes was, and is obtainable from the National Office on requisitition by local recruitment chairmen.
2. Organization of speakers' bureaus which will seek opportunities to address appropriate groups on career training for occupational therapy and requisites for professional success.
3. Exhibits of various kinds in places frequented by youth and parent groups.
4. Contact with libraries in an effort to:
   a. Increase reference material on occupational therapy.
   b. Arrange lectures, exhibits and special collections of a vocational character.
5. Publicity in the local press or in national magazines.
6. Production of visual aids.

Most of these plans have been, or are being implemented. The Maryland Committee Chairman, Mrs. Marshall Price, had an excellent exhibit of books on O.T., photos of O.T. in action and small therapeutic devices, such as specially designed sanding blocks, on display at the Enoch Pratt Free Library in Baltimore, while, on Jan. 26 they sponsored a public meeting attended by upwards of 300 persons. The chief address by Dr. Russek of New York, was broadcast. The following evening there was a television program in which Dr. Dunton and a young and pretty occupational therapist interviewed each other on the meaning and potentialities of occupational therapy.

Mrs. Hauenstein from Massachusetts, says that their Speakers' Bureau now covers the entire state, while in down-state New York, Chairman Miss Doris Richardson, reports about 100 inquires resulting from their informational canvass. All have been acknowledged and referred to A.O.T.A. or other sources for suitable reply. Miss Richardson's committee was one of the few to enclose in the original mailing a card giving the name and address of the local chairman.

In this connection the Recruitment Committee has been faced with a vexing problem. At the Detroit meeting it was recommended that the covering letter included in the original informational canvass should be signed by the local recruitment chairman, so that all replies could be processed locally, and the local group could gauge the efficacy of their campaign by the volume of response elicited. The impracticability of this course, however, soon became evident. Not only would the labor and expense of cutting stencils be enormously increased, but it was felt that

many local chairmen would not have facilities for handling any considerable response. Moreover, personnel of the national committee is, itself, unstable. For example, three resignations have occurred since Sept. 1949, and in one state no successor was appointed for more than three months.

It has therefore been the practise to send out all form letters over Miss West's signature and in envelopes bearing the address of the National Office. The undisputed gain in efficiency is at the cost of the poor local committees, who gallantly shoot their arrows into the air, but have no idea whether they have hit the target or not. Practical suggestions for the resolution of this problem are earnestly solicited from recruitment committees and the A.O.T.A. membership at large.

It must not be thought that Maryland, Massachusetts and New York are the only states with active programs. Other committees have also been busy as the following tabulated report shows.

Ch. and Adults, Assn. for Cr. and Dis., American Legion, Venture Club, Amer. Assn. of Univ. Women, Bus. and Prof. Women's Assn., Parent-Teacher Assn., Chamber of Commerce, Professional Assns. of MDs, PTs, nurses, teachers, engineers, many church and youth groups, including high school and college clubs.

The National office has also been active. Besides literature supplied for state mailings, 26,000 brochures have been distributed through other channels, mainly O.T. schools, individual O.T.R.s, the Association's mailing list of vocational guidance personnel and general inquiries. Other activities include: two exhibits three speakers's engagements, preview and announcement of available films, contact with two Federal agencies for revision of occupational information handbooks, participation in a career day and in the programs of eight allied organizations. Planned but not yet executed are magazine articles and film strips.

Meanwhile the National Chairman and the A.O.T.A office, besides organizational and distribution duties,

Key Pl: Planned Y: Yes

STATE	No. of Mailings in Informational Canvass	Radio	Television	Engagements by Speaker's Bureau	Estimated Audience	Newspaper Publicity	Library Canvass	Career Day	Window Display	State Bureau of Vocational Guidance	Slides or Movies	Participation in Programs of Other Associations	Other: Mass Meeting (a) Scholarship (b)
Alaska	32	1					Y					Y	
Ky.						Pl	Y			Y		Y	
Md.	125	1	1	12		Y	Y		5	Y		Y	a
Mass.	600	Pl	Pl	10		Y	Pl			Y		Y	
Mich.			Pl			Y	Y		Y	Y			
Minn.		Pl		Pl		Y			Y	Y		Y	b
Mo.	700			4	140	Y	Y	Pl	Pl	Y	Pl	Y	
Mont.	232	1		3	200	Y	Y		Y	Y		Y	
Met. N. Y.	450			3	175	Y	Y		Y	Y		Y	
N. Cal.	300			4	500		Pl			Y	Pl		
N. Dak.	282	Pl		Pl			Y		Pl	Y			
S. Cal.	45			5	300		Y	Y	Y		Y	Y	
TOTALS	2766	3	1	41	1315	7	9	1	10	10	1	9	2

Many hours of interviews and individual counseling were also reported. Apparently interest in occupational therapy among Vocational Guidance personnel has been greatly stimulated. It was said by one chairman that television should be especially easy to arrange just now because many companies are on the lookout for sustaining programs, which can be run as part of their public service program.

Outside agencies and organizations contacted were listed as local chapters of: Lions, Rotary, Kiwanis, Zonta, Soroptimists, Altrusa, Boy and Girl Scouts, American Tbc. Assn., Campfire Girls, Nat. Soc. for Cr.

have engaged in a considerable correspondance aimed at: —

1. Expediting the *Manual on Careers in the Rehabilitation Field,* of which occupational therapy is one of five. It is hoped that this manual which is being edited by Mr. E. J. Taylor, Dr. Rusk's assistant on the N. Y. Times, and sponsored by the National Society for Crippled Children and Adults, will be released by the summer of 1950. It will be published and distributed without cost to our group.
2. Obtaining newspaper and magazine publicity

for career-training in occupational therapy. Some local successes are recorded. It is expected that the *Ladies Home Journal* will add a booklet on occupational therapy to its High School Careers Series. An article on O.T. in the psychiatric field will appear in one of the spring issues of *Glamour*.

3. Discovering what is being said about occupational therapy in standard reference works. The coverage on the whole, is not bad. See *Occupational Therapy OUTLOOK HANDBOOK*, Bul. 940, US Dept. of Labor, Bu. Labor Statistics in cooperation with Vet's Admin. Ref. Occupational Therapists 5, D.O.T., 0-32.04 Supt. of Documents, Washington, 25, D.C. Price $1.75.

In closing this report the National Recruitment Chairman wishes to say two things. First, letters of suggestion and advice received from time to time are deeply appreciated, and in every case, have been acted upon as circumstances permitted. It has *not* been possible to answer fully, or even to acknowledge all these letters. Nevertheless, sincere thanks herewith go out to the writers, and it is hoped that no one will let silence at this end discourage him or her from writing again and again.

One letter is specially remembered, although all were helpful and inspiring. The situation described is something like this: there are two schools of O.T. in the state from which the letter comes, one in a tax-supported institution, the other in a private college. Both have full enrollments, but the tax-supported institution is faced, at mid term, with the necessity of cutting down its freshman class by about half. The problem cannot be met by referring the rejected students to other O.T. schools because of factors of state pride, and also the more material consideration of the larger fees charged students leaving their own state. The unfortunate result appears to be that the students weeded out of the occupational therapy curriculum are being directed into other fields, and are lost to our profession at a time when new recruits are so urgently needed.

Is it not reasonable to ask the following questions?

1. If the lag in school enrollment is regional, not national, and among the high-fee private schools rather than the tax-supported institutions, should not the latter be encouraged to expand their facilities?
2. Despite the fact of 600 vacancies in the O.T. schools, should not A.O.T.A. encourage the opening of additional courses in the state universities and land-grant colleges?
3. Should not the advisability of returning to the accelerated courses of the war years receive consideration?

My warm thanks also go out to all local Recruitment Chairmen, and to the members of their committees. Most of these laborers in the vineyard will probably remain anonymous, because limitations of space prohibit publication of their names, but great confidence is felt in their devotion to occupational therapy, which prompts them to sacrifice leisure and recreation in the cause of professional growth. Confidence is also felt in their ultimate success.

Recruitment is a long-time job, in which we must be content to build gradually, though never relaxing our efforts. What we can't do in 1950, perhaps we can accomplish in 1951, or 1952, but we will keep on plugging until the need for special activity is past.

Signed:

Susan Colston Wilson, O. T. R.,
Ch'rmn., AOTA Comm. on Rrcruit. & Publ.

ROSTER, A.O.T.A. RECRUITMENT COMMITTEE

Alabama	Mrs. June V. Arber, V. A. Hosp., Tuscaloosa, Ala.
Alaska	Alice M. Hussey, Seward Sanatorium, Bartlett, Alaska
Arizona	Martha J. Young, V. A. Hosp., Phoenix, Arizona
Arkansas	Mabel H. Davis, V. A. Hosp., No. Little Rock, Ark.
No. California	Eleanor Jean Wood, 5 Tanglewood Road, Berkeley, Calif.
So. California	Elizabeth Engelke, O.T. Dept., U. of S. Cal., Los Angeles 7, Cal.
Colorado	Joan Ryan (Mrs. B. W.) Rural Route 1, Box 575, Ft. Collins, Col.
Connecticut	Joan L. Roy, Hartford Rehab. Workshop, 680 Franklin Ave., Hartford 6, Conn.
Washington, D.C.	Lt. Col. Ruth A. Robinson, O.T. Sec., WMSC, Office Surg. Gen'l., U. S. Army, Washington 25, D. C.
Florida	Thelma Laidman, V. A. Hosp., Coral Gables, Fla.
Georgia	Gertrude Murray, Lawson V. A. Hosp., Atlanta, Ga.
Hawaii	Catherine E. Nourse, Bur. Crippled Children, Honolulu, T. H.
Idaho	Mrs. Audrey P. Navarre, 1005 No. 9th St., Boise, Idaho
Illinois	Mary McDonough, Downey V.A. Hosp., Downey, Ill.
Indiana	F. Evelyn Marsh, Riley Hosp., Indianapolis, Ind.
Iowa	Mrs. Janet S. Fields, 119½ So. Dubuque St., Iowa City, Iowa
Kansas	Penelope Boxmeyer, 3101 Gilham Plaza, Kansas City 3, Mo.
Kentucky	Dorothea Baldwin, V. A. Hosp., Outwood, Ky.

Maryland	Mrs. Marshall Price, Box 6815, Towson 4, Md.
Massachusetts	Mrs. Phyllis Hauenstein, V. A. Hosp., Bedford, Mass.
Michigan	Alice Hilarides, Eastern Orthop. Sch., Grand Rapids, Mich.
Minnesota	Mrs. Carol Tammen, 4225 Brunswick Ave., Minneapolis 16, Minn.
Mississippi	Shirley A. Garland, Box 147 Sta. B., Gulfport, Miss.
Missouri	Helen D. Harkness, 4567 Scott Ave., St. Louis 10, Mo.
Montana	Caroline Haskins, V. A. Center, Ft. Harrison, Mont.
Nebraska	Mrs. Jane Moffatt Spulak, Lincoln State Hosp., Lincoln, Neb.
New Jersey	Mrs. Gail S. Fidler, V. A. Hosp., Lyons, N. J.
New Mexico	Maude K. Stack, V. A. Hosp., Albuquerque, New Mex.
New York	Doris Richardson, 140 Washington Ave., New Rochelle, N. Y.
New York, West	Cornelia Smith, Willard State Hosp., Willard, N. Y.
N. New England	Sarah Thorndike, 105 Pleasant St., Concord, N. H.
North Carolina	Martha Matthews, Box 3440, Duke Hosp., Durham, N. C.
South Carolina	Martha Matthews
North Dakota	Mrs. Geo. P. Brenner, Box 1463, Jamestown, N. Dak.
Ohio	Rachel Martiny, Rehab. Center, 2239 E. 55th St., Cleveland, Ohio
Oklahoma	Barbara Layton, Central State Hosp., Norman, Okla.
Oregon	Grace Black, U. of Oregon Med. Sch., Portland, Ore.
Pa. & Del.	Emiko Ishiguro, U. of Pa. Hosp., 34th & Spruce St., Phila.
Pa. West	Margy Semenow, 2005 Wendover St., Pittsburgh 17, Pa.
Rhode Island	Louise F. Talcott, 249 Blackstone Blvd., Providence 6, R. I.
Tennessee	Virginia Stockwell, V. A. Hosp., Memphis, Tenn.
Texas	Cathryn Curran, V. A. Hosp., Temple, Tex.
Utah	Mrs. Dorothy H. Whitlock, State Tbc. San., Ogden, Utah
Virginia	Margaret D. Clark, V. A. Hosp., Richmond, Va.
Washington	Edna-Ellen Bell, College of Puget Sound, Tacoma, Wash.
West Virginia	Anne Holtzworth, Morris Memorial Hosp., Milton, W. Va.
Wisconsin	Polly Birdsall, Rm. 146, No. Captiol, Madison 2, Wis.

Essentials of An Acceptable School of Occupational Therapy

Revised to December 1949

PREPARED BY THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS OF THE AMERICAN MEDICAL ASSOCIATION

Preamble

The Council on Medical Education and Hospitals of the American Medical Association, the Council on Physical Medicine and Rehabilitation of the American Medical Association and the American Occupational Therapy Association are directly concerned in the training of occupational therapists. The Council on Medical Education and Hospitals establishes standards, inspects and approves schools and publishes lists of acceptable schools. With the cooperation of the Council on Physical Medicine and Rehabilitation and the American Occupational Therapy Association standards have been established for this type of training for the information of physicians, hospitals, schools, prospective students and others, and for the protection of the public.

Therapists are being trained in these schools to work under the direction of qualified physicians and not as independent practitioners of occupational therapy.

I. Organization

1. Occupational therapy schools should be established only in medical schools approved by the Council on Medical Education and Hospitals or in colleges and universities affiliated with acceptable hospitals and accredited by the Association of American Universities or the respective regional associations of colleges and secondary schools.

2. The schools should be incorporated under the laws regulating nonprofit organizations. The control should be vested in a board of trustees composed of public spirited individuals having no financial interest in the operation of the school. The trustees should serve for reasonably long and overlapping terms. If the choice of trustees is vested in any other body than the board itself, this fact should be clearly stated. Officers and faculty of the school should be appointed by the board.

3. Hospitals are required for clinical practice but should not attempt to operate a school of occupational therapy independently.

II. Resources

4. Experience has shown that an adequate school of occupational therapy cannot be maintained solely by the income from students' fees. No occupational therapy school, therefore, should expect to secure approval which does not have a substantial additional income.

*Reprinted from *The Journal of the American Medical Association*, Vol. 141, No. 16, Dec. 17, 1949, page 1167.

III. Faculty

5. The school of occupational therapy should have a competent teaching staff graded and organized by departments. The director of the school should be a qualified occupational therapist whose qualifications are acceptable to the Council on Medical Education and Hospitals, who has had at least three years clinical experience, is registered or eligible for registration and has an academic degree. The clinical training in a school of occupational therapy should be under the direction of a physician or a committee of physicians whose quilifications are acceptable to the Council. If a committee provides the direction, the chairman should be designated as medical director. An advisory committee may also be established including representatives from the departments of the college, university or medical school which participate or cooperate in the teaching of occupational therapy students.

IV. Plant

6. The physical plant should provide adequate lecture rooms, class laboratories and administration offices. Equipment should be adequate for efficient teaching in the various departments.

7. A library of adequate space and availability and containing standard texts and leading periodicals in occupational therapy should be provided.

V. Administration

8. Supervision.—There should be careful and intelligent supervision of the entire school by a director with sufficient authority to maintain the established standards.

9. Records.—There should be systematic records showing credentials, attendance and grades of the students.

10. Credentials.—The admission of students to occupational therapy schools should be in the hands of a responsible committee or examiner. Documentary evidence of the students' preliminary education should be obtained and kept on file.

11. Advanced Standing.—At the discretion of the administration, advanced standing may be granted for work (or experience) required in the occupational therapy curriculum which has been done in other accredited institutions. Official verification of previous work (or experience) should be obtained by direct correspondence. Preliminary qualifications should also be verified and recorded.

12. Number of Students.—The number of students admitted to the training course should be limited by the facilities of the school.

In practical work of a laboratory nature the number of students that can be adequately supervised by a single instructor is in general experience about fifteen; in lectures the number may be larger. A close personal contact between students and members of the teaching staff is essential.

13. Discipline.—Each training school reserves the right to drop a student at any time for any cause which the school authorities deem sufficient.

VI. Publications

14. The school should issue, at least biennially, a bulletin setting forth the character of the work which it offers. Such an announcement should contain a list of the members of the faculty with their respective qualifications.

VII. Prerequisites for Admission

15. Education.—Colleges offering training courses in occupational therapy which are combined with work leading to a bachelor's degree should require the candidates for this combined course to comply with the regular entrance requirements of the school concerned. Other candidates should furnish proof of having completed one year of college education or its equivalent.

16. Character.—All candidates should be required to present evidence of good character, general fitness and emotional stability.

17. Health.—All applicants should be required to submit a physical health report including evidence of successful vaccination. All students should be given a medical examination under the supervision of the official school physician as soon as practicable after admission and this examination should include a roentgen examination of the chest.

VIII. Curriculum

18. Length of Course. The minimum length of full time training for the course should be 100 weeks. The course should include not less than 64 weeks of theoretical and technical instruction and not less than 36 weeks of hospital practice training as set forth in succeeding sections.

19. Distribution of Time.—The period devoted to theoretical and technical training should include not less than 64 semester hours of which not less than 39 semester hours should consist of didactic instruction and not less than 25 hours of technical instruction in therapeutic activities.

The curriculum should be so arranged that students placed in hospitals for practical training before the completion of their theoretical and technical instruction should have covered those portions of the curriculum which pertain to the clinical fields to which they may be assigned for practical instruction.

(a) Theoretical: The hours devoted to theoretical training should be still further subdivided as follows:

Required Subjects	Semester Hours
(1) Biologic Sciences to include:	
Anatomy	18
Kinesiology	
Neuroanatomy	
Physiology	
Psychology	
(2) Social Sciences to include:	
Sociology	4
Individual readjustment	
Social and educational agencies	

(3) Theory of Occupational Therapy to include:		
Administration		
General Medicine and Surgery		
Orthopedics		8
Pediatrics		
Tuberculosis		
Psychiatry		
(4) Clinical Subjects to include:		
General Medical and Surgical		
Blindness and deafness		
Cardiac diseases		
Communicable diseases		
Neurology		7
Orthopedics		
Pediatrics		
Psychiatry		
Tuberculosis		
(5) Electives		2
Total		39

(b) Technical: Because of the increasing demands of the medical profession for qualified therapists trained in special fields applicable to the education and training of disabled persons as well as to the treatment of the sick there should be a certain amount of flexibility in technical requirements.

A minimum of 25 semester hours should be devoted to technical training. The major portion of these 25 semester hours may be in one of the following fields, with survey courses in other fields:

(1) Arts—Fine and Applied:
Design, leather, metal, plastics, textiles and wood
(2) Education—Special and Adult:
Home economics, and library science
(3) Recreation:
Music, dramatics, social activities, gardening and physical education

(c) Clinical Training: The time for clinical training should be not less than 36 weeks (nine months). No student should be assigned to a clinical training center for less than eight weeks. (Rotating assignments may be made within a given center so that the student may have varied experience with different patient groups within the one institution. Each of these assignments should be for not less than four weeks.) The division of time in the various fields should be as follows:

Psychiatric conditions	Not less than 12 weeks
Physical disabilities (surgical, neuromuscular and orthopedic)	Not less than 8 weeks
Tuberculosis	4 to 8 weeks
Pediatrics	4 to 8 weeks
General medicine and surgery (other than physical disabilities)	4 to 8 weeks

IX. *Hospital Affiliations*

20. Hospitals or institutions affiliating for clinical training should be carefully selected by the director of the school in consultation with the medical director. No occupational therapy department should be considered for training students unless the director of the department who serves as the instructor is a competent occupational therapist, qualified to supervise students.

21. The school, at the beginning of each clinical assignment, should supply the instructor in charge with pertinent information regarding students' education, experience, special abilities and health.

22. The instructors in the clinical training departments should be considered members of the extramural staff of the school. As such they should be familiar with the content of the school courses pertinent to the particular area of occupational therapy in which students are being trained so that effective correlation of didactic and clinical training may be achieved. An outline of the clinical training program should be submitted to the school with which affiliation is maintained.

23. Each affiliated institution should have a well defined program to interpret the function of occupational therapy in its own area or type of service, including the following:

a. Orientation to the program of the institution
b. Interpretation of objectives
c. Participation in treatment procedure
d. Methods of determining progress, evaluation and recording results
e. Teaching procedure in technical media most frequently used
f. Plan for patients on discharge
g. Organization and administration of the occupational therapy department

There should also be a planned program of lectures, clinics, staff meetings, conferences, etc., to give the student adequate understanding of the the medical background and allied professional services in the field or fields in which each institution is concerned.

24. Written records of patient progress and case studies should be submitted to the instructor in charge by each student. Students must obtain satisfactory rating in clinical training before the diploma is granted.

25. Each instructor should maintain records covering the student's personal adjustment and general abilities. A report based on these records should be sent to the school on the termination of the student's period of training.

X. *Admission to the Approved List*

26. Application for approval of a school of occupational therapy should be made to the Council on Medical Education and Hospitals of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Forms will be supplied for this purpose on request. They should be completed by the administrator of the institution requesting this approval. Inquiries regarding the registration of qualified therapists should be addressed to the American Occupational Therapy Association, 33 West 42nd Street, New York 18, New York.

27. Approval may be withdrawn whenever in the

opinion of the Council a school does not maintain an educational service in accordance with the above standards. Whenever a training program has not been in operation for a period of two consecutive years, approval may also be withdrawn.

28. Approved schools should notify the Council on Medical Education and Hospitals whenever personnel changes occur in relation to the director or medical director of the school.

Meeting of the House of Delegates

American Occupational Therapy Association
Book Cadillac Hotel, Detroit, Michigan
August 21, 22, 25, 1949

The meeting was called to order by the Speaker, Miss Edna Faeser. The Secretary, Miss Elizabeth Collins, called the roll. Those present were:

Association	*Delegate*
California, Northern	Meryl N. Van Vlack
California, Southern	Carlotta Welles
Colorado	Josephine Davis
Connecticut	June Sokolov
District of Columbia	Violet Corliss
Hawaii	Eleanor Brodsky
Illinois	Angeline Howard
Indiana	Edna Faeser
Iowa	Maxine Ferrell
Kansas	Louise McMillen
Kentucky	Nell McCulloch
Maryland	Eleanor S. Owen
Massachusetts	Elizabeth Collins
Michigan	Janet M. Paterson
Minnesota	Phyllis Lueck
Missouri	Etta Harkness
New England, Northern	Doris Wilkins
New Jersey	Naida Ackley
New York	Blanche Ringel
New York, Western	Cornelia Smith
Ohio	Mildred Schwagmeyer
Oregon	No representative
Pennsylvania	Ruth V. Greve
Pennsylvania, Western	Dorothy J. Wirt
Texas	Fanny B. Vanderkooi
Virginia	E. Dorothy Deer
Washington	Marian L. McKinnon
Wisconsin	Jeanne Foy

Twelve alternate delegates also attended the meetings and participated in the discussion.

REPORT OF THE SECRETARY OF THE HOUSE OF DELEGATES.

The secretary reported that two associations have submitted requests for affiliation with the House of Delegates and the A. O. T. A., the Tennessee Occupational Therapy Association and the Oklahoma Occupational Therapy Association. The committee on Credentials has reviewed the applications and the constitutions of these two associations. The Committee reported that the Tennessee Association meets all the requirements and that its constitution is in order; that the Oklahoma Association meets all requirements and that except for minor discrepancies its constitution is in order. The committee recommended that the Tennessee Association be accepted for membership; that the Oklahoma Association be accepted for membership with the proviso that its constitution be amended to meet minimum requirements.

It was voted: That the recommendation of the Committee on Credentials be accepted and that the Tennessee Occupational Therapy Association and the Oklahoma Occupational Therapy Association be accepted for membership.

REPORT OF THE COMMITTEE ON CREDENTIALS.

Miss Elizabeth Collins, Chairman of the Committee on Credentials, reported that no credentials had been received for the Minnesota delegate. The president of that association was present in the absence of both the delegate and the alternate delegate.

It was voted: That the president of the Minnesota Association be permitted to serve in the capacity of delegate.

The chairman reported that there are still minor discrepancies in the constitutions of some of the state and regional associations. The Committee recommended that no further revisions be required until definitely stated minimum requirements for state and regional associations have been formulated and officially adopted.

It was voted: That the recommendation of the Committee on Credentials be accepted.

Admission of New State Associations. The delegates of the two new associations were welcomed to the House of Delegates.

Association	*Delegate*
Tennessee	Elizabeth Winters
Oklahoma	Dorothy Mann

Appointment of Nominating Committee. The Speaker appointed the following committee:

Josephine Davis, Chairman
Cornelia Smith
Elizabeth Collins

REPORTS TO THE HOUSE OF DELEGATES.

Mrs. Winifred Kahmann, President of the AOTA. The President greeted the members of the House of Delegates and thanked them for their response to the appeal for names of members willing to serve on committees of the AOTA. Fourteen associations complied with this request but many of the replies were not received until after the committees had been organized. About 120 members are now serving on the standing committees of the AOTA. The delegates were requested to continue to submit names of members who are capable and willing to devote time and effort in such service.

Mrs. Kahmann announced that Miss Susan Wilson has been appointed Chairman of a Special Committee for Recruitment. This committee is to organize and coordinate a national recruitment drive which is to be carried on by the state and regional associations through local recruitment chairmen. The shortage of qualified therapists has created a critical situation and it seems inevitable that we must think of some other means of supplementing occupational therapy services in certain areas. The idea was projected that perhaps there should be special emphasis toward the recruitment of advance standing students. The President reminded the delegates that although the recruitment drive is of major importance it is not the enitre answer to the problem. The reputation of the profession is being jeopardized and we are losing prestige in the medical field because of the rapid turn-over of personnel.

Miss Clare Spackman, Treasurer of the AOTA. The Treasurer presented a layman's summary of income and expenses for the past fiscal year and the proposed budget for the next year. For the first time since 1946 the AOTA will end the year with an appreciable surplus. This is due to several reasons: the efficient management of the national office, the new system of collecting dues and registration fees, the voluntary contributions of state and regional associations and increased revenue from conventions. A reserve fund can now be set up as a start toward insuring financial security for the national office and the education office. Individual items on the proposed budget were discussed. Included are salary increases for the entire staff of the national office and the editor of AJOT. Also included is the salary

for an additional employee in the national office. The budget for the education office was discussed. Since 1946 the Kellog Fund has provided $34,000 for the support of the education program but this income will be terminated after next year's grant of $8,000. A new three year project "Instruments for Selecting Candidates for Schools of Occupational Therapy" will be financed by a grant of $21,000 from the Grant Foundation.

It was voted: That the House express to the Board its unanimous approval of the proposed budget.

Board Action: Budget approved. The problem of enforcing the constitutional requirements regarding dual membership in the AOTA and the state and regional associations was discussed. The constitution of the AOTA states:

> "That when there is a state or regional association recognized by the AOTA, active members of the AOTA must be active members of their state or regional association."
>
> "That active members of affiliating state and regional associations eligible for active membership in the AOTA must become active members of the AOTA and pay the established membership fee."

The Treasurer reported that in an effort to encourage voluntary acceptance of these requirements a new plan will be tried next year. On or before February 15th the national office will send to each association a list of all members in that area who have paid AOTA dues for the current year. In return the treasurer of each association is requested to send to the national office a list of all members who have paid state or regional association dues for the current year. It is hoped that by this method those members of either the national association or the local associations who are not active members of both may be located and encouraged to become active participating members of both the national and the local association.

Another possible solution to the problem was projected: That the annual dues for active members of the AOTA be $8.00 plus a uniform amount for state or regional association dues, both due and payable at the same time to the national office. The state dues would be refunded to the affiliated state or regional association of the member's residence at the time the dues were paid. Each member of the AOTA would thus automatically become a member of an affiliated state or regional association and any member changing residence during the year would automatically become a member of the affiliated association of his or her new residence. If a member resides in an area where there is no state or regional association the amount of the annual state dues paid by that member would be placed in a fund to be paid to that state or regional association when it is organized and affiliated. This plan is currently used by the American Physical Therapy Association, the American Dietetic Association and other similar organizations. It would seem to warrant consideration by the AOTA.

In the discussion which followed it was found that the present annual dues for state and regional associations range from $2.00 to $4.00. It was the general opinion that such a plan would be an incentive for groups in areas which have no state or regional associations to organize and affiliate. It was also felt that an effort should be made to determine the attitude toward such a plan of the members residing in areas where there are no affiliated associations.

It was voted: That the proposal that annual dues for active members of the AOTA be $8.00 plus a uniform amount for state and regional association dues, both due and payable at the same time to the national office, be referred to the local associations for discussion; that it be included on the 1950 agenda for the House.

It was further voted: That the House recommend to the Board that if the mechanics for enforcing the rulings regarding dual membership in the AOTA and the local associations cannot be found that these rulings be deleted from the constitution of the AOTA.

Board Action: Deferred until the plan presented by the Treasurer of the AOTA has been tried and the alternate plan which has been suggested and referred to the local associations for study has been considered.

Miss Wilma West, Executive Director. Miss West reported that since the cost of publishing the 1949 Yearbook was less than the cost for publishing the 1948 Supplement to the Yearbook, it seems likely that it will be possible to publish a complete Yearbook annually.

In order that the membership may be kept informed regarding matters of current interest it is planned to resume the *Newsletter*. This will be sent to the membership bi-monthly, alternating with AJOT.

Miss West suggested that the Placement Service maintained by the national office might better be called a Job Information Service. During the past year only 81 known placements were made by the national office although there were nearly 3000 referrals to about 200 applicants for approximately 500 vacancies.

Miss Eva Otto, Educational Field Secretary. The education office is continuing the educational research program instituted in 1946 and financed by the Kellog Foundation. Thirteen different projects are in progress. The aim of the present program is to assist the schools and the clinical training centers in unifying and standardizing their programs and to assist in evaluating these programs. A new project, the development of student selection instruments, will be started during the coming year.

Miss Helen Willard, Chairman of the Education Committee. During the past year the efforts of the Education Committee have been directed toward working out plans and procedures on three matters of major importance.

Recruitment: With no marked increase in the number of students enrolled in the accredited schools of occupational therapy and with the present acute shortage of qualified therapists concerted action is necessary if the profession is to grow and develop. The existing schools could enroll approximately 600 additional students. They do not have the applicants. The great need today is for public education regarding the profession, what it is and the opportunities which it offers.

Relationship between occupational therapy and physical medicine: The Committee is working on a statement of policy more specific than the one which was presented by the committee last year and approved by the House of Delegates and the Board of Management. The delegates were requested to explain to their members the significance of the proposals projected by the Council on Physical Medicine of the American Medical Association regarding Essentials for Acceptable Schools of Occupational Therapy. (Speaker's letter, April 1949). There has been no action on the proposals as yet. The official representatives of the AOTA will continue negotiations with the various committees of the AMA concerned with the revision of the Essentials. The American Psychiatric Association has formulated a statement of policy to clarify the relationship between occupational therapist, psychiatrists and physiatrists. Statements from other similar groups would help to strengthen the contention of the AOTA that the schools of occupational therapy should not be under the direction of any one medical specialty group and that there should be direct relationship between the occupational therapist and the attending physician who is in charge of the total treatment of the patient. The education office will continue its program of establishing standards and evaluating schools and clinical training centers.

In-service training program for psychiatric aides in occupational therapy: There are not enough registered occupational therapists to meet the needs of the psychiatric institutions. Positions in these institutions either remain vacant or are being filled by untrained personal. In an effort to offer as much assistance as possible and in the belief that the aide with some training in occupational therapy will be better able to serve the patients, the Sub-committee on Psychiatry of the Education Committee of the AOTA has outlined a three months in-service training program for psychiatric aides in occupational therapy. In planning the program the committee has been guided by the principles set forth by the Board in March. (1) That there be consultation with the APA (2) that courses be given only under the supervision of an OTR (3) that graduates of the course work only under the supervision of an OTR (4) that consideration be given to some type of certification (5) that certification be dependent upon continued employment (6) that graduates be eligible for an associate, or associate subscriber, membership in the AOTA.

The proposed program has been presented to the Com-

mittee on Medical Rehabilitation of the American Psychiatric Association for its consideration and recommendations. No reply has as yet been received. If the program is approved each state department of mental hygiene, or its equivalent, will be encouraged to establish an in-service training program in at least one hospital where adequate supervisory personnel is available.

The delegates were urged to explain the proposed program and the need for the program to their members. It was also suggested that the local associations contact the proper agencies in their respective areas and express their willingness to assist with any program which may be undertaken.

A statement of policy regarding the proposed in-service training program was formulated by the Board and sent to the House of Delegates for consideration.

It was voted: That the House express to the Board its unanimous approval of the statement of policy.

Board Action: Approved.

The Chairman of the Sub-committee on Clinical Training reported that a resume of the work of the committee will be sent to the delegates.

Mrs. Lucie Murphy, Editor of AJOT. Circulation has increased during the past year from 2800 to 3300. A more extensive promotional and advertising campaign is planned for the coming year.

Mrs. Murphy reported that there is a dearth of material for publication. She asked that the delegates urge the members of the local associations to submit articles for publication as well as to solicit articles which would be of value and interest to the profession.

The editor expressed her thanks for the very good responce to the purchasing power survey. The results reveal a purchasing power of over $1,500,000. Leather and weaving supplies rank highest. The delegates were requested to urge their members to patronize AJOT advertisers and to send the names of other potential advertisers to the editor. The name of the advertising agent or the salesman is more helpful than the name of the company only.

Mrs. Lucie Murphy, Chairman, Permanent Convention Committee. The 1950 annual meeting of the AOTA will be held at the Colorado Hotel, Glenwood Springs, Colorado. The hotel operates on the American Plan and the dates are October 14 to 21.

Miss Martha Jackson, Constitution Committee. Copies of the proposed changes in the Constitution of the AOTA were distributed. The Chairman explained that the revisions are relatively minor ones which are being proposed in order to provide legality for accepted procedures. The committee recommended that the proposed revisions be presented to the membership for vote at the next annual meeting of the AOTA. The committee further recommended that a committee be appointed to make a thorough study of the Constitution of the AOTA and to draw up an entirely new constitution for presentation to the membership; that the present constitution, or the constitution revised according to the proposed changes, continue in effect for such time as may be needed to complete the study and draft a new constitution.

It was voted: That the House express to the Board its approval of the recommendations made by the Constitution Committee.

Board Action: Approved.

Report of Life Membership Committee. Miss Doris Wilkins, Chairman, distributed copies of the report of this committee. A plan for Life Membership at a flat rate of $200.00 was presented. The committee recommended to the House of Delegates that a plan or choice of plans for Life Membership be presented to the Board of Management, either on the financial basis recommended by the committee, or as a reward for years of service as a member of the AOTA.

Following discussion, *it was voted*: That the House accept the report of the committee to date; that the proposed plan be presented to the state and regional associations for study and discussion; that the delegates report to the Chairman of the Life Membership Committee regarding membership opinion and the number of members who might be interested in the single payment plan; that the matter be included again on the 1950 agenda for the House.

OLD BUSINESS

Should the Delegate be Permitted to hold Office, other than that of Delegate, in the State or Regional Association. Following discussion, *it was voted*: That the matter be left to the individual associations with the recommendation that when members are available they should be used to the best advantage; that no such ruling should be made mandatory by this body.

Desirability or Feasibility of Holding House of Delegates Meetings Twice a Year. Following discussion, *it was voted*: That the House of Delegates shall meet annually at the annual convention of the AOTA.

Consideration of the Month of March as a Permanent Date for the Annual Convention. Following discussion, *it was voted*: That the House express to the Board its opinion that a Fall date, preferrably the third week in October, would be the most desirable time for the annual convention.

Board Action: Referred to the Permanent Convention Committee with the understanding that variations in date may be necessary depending upon the location and type of hotel.

Proportional Representation in the House of Delegates. Following discussion, *it was voted*: That the present representation in the House of Delegates be continued.

Equal Representation on the Board of Management. The delegate of the Washington association, which had submitted this topic, requested that it be withdrawn.

It was voted: That this topic be deleted from the agenda.

Formation and Function of the House of Delegates. Rotation plan for the election of delegates. Following discussion, *it was voted*: That one third of the affiliated associations shall elect delegates each year for a three year term; that in the event a delegate is unable to complete the three year term a new delegate shall be elected to complete the term; that a committee be appointed to set up an election schedule to implement this action; that new associations shall be assigned to each of the three groups in succession.

The following committee was appointed:

Naida Ackley
Elizabeth Collins
Josephine Davis

The committee submitted the following rotation schedule for the election of delegates:

1950 *and every* 3 *years thereafter*
Colorado
Hawaii
Illinois
Massachusetts
Minnesota
Western New York
Ohio
Oregon
Virginia
Kansas

1951 *and every* 3 *years thereafter*
California, Northern
California, Southern
Indiana
Iowa
Kentucky
Maryland
Northern New England
Pennsylvania
Wisconsin
Michigan

1952 *and every* 3 *years thereafter*
Connecticut
District of Columbia
Missouri
New Jersey
New York
Western Pennsylvania
Texas
Washington
Tennessee
Oklahoma

It was voted: That the report of the committee be accepted.

Uniformity of date on which delegates assume office. Following discussion, *it was voted*: That the annual meet-

ings of the affiliated associations shall be held in March, April or May (1946 ruling); that all delegates shall assume office on the first day of July following their election; that the names and addresses of new delegates shall be sent to the national office, the editor of AJOT and the officers of the House prior to the first of July so that mailing lists may be revised on that date.

Clarification of terms of Delegate Board Members. At the 1948 annual meeting it was voted "that a delegate be eligible for election as a House Officer or Delegate Board Member at the end of the first session of the House of Delegates at which she serves."

To clarify this statement, *it was voted*: That the Delegate Board Members shall be elected from among those members of the House of Delegates who are serving their first year as the elected delegates of their respective associations; that their terms shall be for two years.

Clarification of term of Speaker on the Board of Management. Following discussion, *it was voted*: That the Speaker of the House shall be elected for a two year term from among those members of the House of Delegates who are serving their first year as the elected delegates of their respective associations; that the Speaker shall serve as one of the six Delegate Board Members.

Discussion of organization of House of Delegates. It was generally agreed that wider participation by the members of the House in the activities of the AOTA would result in a better informed body of delegates with more understanding and awareness of the needs and problems of the membership and the AOTA.

It was voted: That we express to the President of the AOTA our interest in committee work; that the delegates would like to be used on committees where and when practical.

Minimum requirements for state and regional associations. Recognizing the need for definitely stated minimum requirements for state and regional associations, for the study and possible complete revision of the Formation and Function of the House of Delegates and for a Delegates' Manual, *it was voted*: That the Chairman of the Committee on Credentials serve as Chairman of a House Committee to formulate minimum requirements for state and regional associations for presentation to the House; to study the Formation and Function of the House of Delegates and, in cooperation with the Constitution Committee of the AOTA, make recommendations to the House; to compile a Delegates' Manual for presentation to the House.

It was further voted: That the Chairman of this Committee may appoint the members of the committee; that the committee may be composed of any present or past members of the House of Delegates or any active members of the AOTA.

Recruitment. Miss Susan Wilson, Chairman of the Recruitment Committee, explained the over-all policies and objectives of the recruitment program. The delegates were requested to assist the local recruitment chairman in interpreting the program to their members and in effecting local recruitment projects.

Discussion of Requirement that Active Members of the AOTA must be members of the State and Regional Association and Vice Versa. Discussion and action included in Treasurer's report.

Discussion of Voting Rights of Associate Members in in Local Associations. Following discussion, *it was voted*: That only the active members of the state and regional associations be permitted to vote on matters pertaining to the AOTA.

Discussion of Responsibility of State and Regional Associations for Expenses Incurred by the Delegate in Attending Meetings of the House. Following discussion, *it was voted*: That it is advisable that the state regional associations give consideration to the expenses incurred by their delegates in attending meetings of the House.

Discussion of Contributing to AOTA by State and Regional Associations. The Treasurer thanked the delegates for the voluntary contributions sent to the AOTA by their respective associations. There was no further discussion.

Placement Service. The Executive Director reported on the Placement Service maintained by the national office. There was no further discussion.

Unified Yearly Programs. Following discussion, *it was voted*: That the delegates be advised at the meetings of the House regarding the current projects and problems of the AOTA in order that they may be considered in planning local programs and projects.

Discussion of Examinations for Occupational Therapists Employed in Public Institutions. Miss Elizabeth Messick, Chairman of the Legislative and Civil Service Committee, reported that approximately one third of the members of AOTA are employed in institutions having civil service requirements and classifications. This Committee offers its assistance on any problems pertaining to standards, examinations, classifications, job descriptions, retirement benefits, social security, etc. Requests for assistance should be addressed directly to Miss Messick. A packet of sample forms and general information is available, on loan, from the national office. It was suggested that the Medical Practice Act of the individual states be investigated to discover if regulations pertaining to occupational therapy might be included.

NEW BUSINESS

Use of Transfer Forms for Courtesy Transfer of Membership. At the 1947 meeting of the House of Delegates it was voted that the state and regional associations adopt the policy of courtesy transfer of membership. A member in good standing who is transferring from one association to another should be given a transfer form signed by the Treasurer of the Association which the member is leaving to be presented to the Treasurer of the Association to which the member is transferring. At the same time the Treasurer should send a duplicate transfer form to the national office in order that the files may be kept up to date. Transfer forms were sent to all of the delegates last year. If additional forms are needed they may be secured from the national office.

The discussion which followed revealed that this ruling is not always observed. The Treasurers of the respective associations should be reminded that the policy of courtesy of transfer of membership, including the issuing of the transfer forms, is a House ruling which must be observed.

Provision for Appointment of Substitute Alternate Delegate. Following discussion, *it was voted*: That the present ruling which states that only the elected delegate or the elected alternate delegate will be recognized by the House be amended to provide for the apointment and recognition of a substitute alternate delegate in the event that neither elected delegate nor the elected alternate delegate can attend a meeting of the House; that in such an event the Board or Executive Committee of the local association shall have the right to appoint a substitute alternate delegate who shall have all of the qualifications required of the regularly elected delegates; that the substitute alternate delegate shall have all of the privileges of the regularly elected delegate at those sessions of the House to which she has been appointed.

Discussion of Advisability of Employing a Stenotypist to Record the Minutes of the House of Delegates. The Formation and Function states that "it is the duty of the Speaker to request a stenotypist to record the minutes of the House of Delegates at the annual meeting." Experience to date would seem to indicate that the value of this service in not proportionate to its cost.

In the discussion which followed it was the general opinion that a stenographer who has some understanding of the matters to be discussed would be better able to intelligently record the proceedings of the House and to make a quick summary of pertinent actions for Board and membership reports. If one of the delegates assumes this responsibility it was felt that the alternate delegate of that association, if present, should be permitted to serve in the capacity of delegate.

No recommendations were made but it was suggested that the voluntary offer of any present or past delegate or alternate who can take shorthand notes and type would be most appreciated. If no one volunteers it was suggested that the Speaker confer with the delegate of the area in which the annual meeting is to be held regarding secretarial assistance.

Discussion of the Men's Committee of the New York

Occupational Therapy Association. Following discussion, *it was voted*: That the House request of the Board clarification and further explanation of the existence of the Men's Committee of the New York Occupational Therapy Association which has published a Directory of "Men in Occupational Therapy", all of which seems contrary to the action taken by the Board at the March meeting.

Board Action: In response to this request the Board replied that the Men's Committee of the New York Occupational Therapy Association is a special committee of that association and not a committee of the AOTA. At the March meeting the Board considered a request from the Men's Committee of the New York Association to organize a men's group within the AOTA. It was the decision of the Board "that the profession needed the combined efforts of all occupational therapists working together rather than divided, and that all had the same opportunity and obligation to contribute on both local and national levels. The Board opposed the formation of a men's group as such and urged their cooperative participation in professional activities with women." In compliance with this decision of the Board no Men's Committee of the AOTA has been formed. The Directory of "Men in Occupational Therapy" was compiled and published by the special committee of the New York Association. The Board invites the active participation of these members in the activities of the state and regional associations. With the increasing number of men who are registered occupational therapists, it is suggested that ,as of now, the members of the AOTA refrain from referring to OTR's as *she* and *her*.

International Reciprocity. The following policy regarding international reciprocity was recommended to the Board by the Registration Committee:

(1) That, examination eligibility be amended to include graduates of foreign occupational therapy schools accrediting agencies. This could be the country's medical association, occupational therapy association, or other qualified professional organization.

(2) That, in the case of foreign-trained applicants, work reports may be substituted for clinical training reports, since the latter will no doubt vary from our own or may not be available at all.

(3) That, as in the case of our own graduates, a recommendation for the examination be secured from the school director and that the applicant be considered eligible only of he is a member in good standing of his own association.

(4) That the applicant have worked for at least one year under an OTR in this country, before she be considered eligible for the registration examination and that she have a recommendation from that OTR.

(5) The above recommendations to be applicable only for graduates from schools in England, Australia and Africa. Future requests from other countries to be brought to the attention of the Board.

The Committee's report was accepted by the Board and sent to the House for consideration.

Following discussion, *it was voted*: That the House express to the Board its approval of the recommended policy regarding international reciprocity.

Board Action: Approved.

Re-registration. The Registration Committee recommended to the Board that the ruling regarding re-registration for those who have allowed registration to lapse be amended to provide: That those permitting registration to lapse be required to pay all back fees to be reinstated; that, in addition, those who permit registration to lapse more than five years be required to take the registration examination for reinstatement.

The Committee's report was accepted by the Board and sent to the House for consideration.

Following discussion, *it was voted*: That the House express to the Board its approval of the proposed ruling regarding re-registration.

Board Action: Approved.

ELECTION OF HOUSE OFFICERS AND DELEGATE BOARD MEMBERS.

The results were:

Speaker of the House of Delegates—Edna Faeser (second year of two year term)
Vice-Speaker of the House—Dorothy J. Wirt
Secretary of the House—Nadia Ackley
Delegate Members of the Board of Management
Blanche Ringel
Violet Corliss
Elizabeth Withers

REPORT OF ACTIONS OF BOARD OF MANAGEMENT.

Format of AJOT. The editor of AJOT recommended to the Board that the format of AJOT be changed to a more standard size in order to facilitate the use of reprints and cuts from other similar publications.

Board Action: Approved. The format of AJOT will be changed January 1950.

Other actions of the Board of Management are included in the body of the minutes of the House of Delegates.

Meeting Adjourned

Speaker of the House of Delegates
(Signed)
Edna Faeser, O.T.R.

DELEGATES DIVISION

WESTERN PENNSYLVANIA

Delegate-Reporter, Dorothy J. Wirt, O.T.R.

On February 25, 1949, the Western Pennsylvania Occupational Therapy Association held a special meeting for the purpose of discussing the need to reorganize. We are happy to submit the following report as a record of the progress made since that meeting.

At the present time there are 22 active occupational therapists in our area, which comprises that part of Pennsylvania west of the Alleghenys. Of these, 18 are active members. Miss Lois Clifford, as membership chairman, deserves much credit for this high percentage.

Our successful year is the result of much work on the part of the officers elected at the reorganization meeting. They were Mrs. Gertrude Deibler Sobolewski, President, Miss Marjorie Roth, Vice President, Miss Ann Kevilus, Treasurer, Mrs. Helen Frantsits, Secretary, and Miss Dorothy Wirt, Delegate.

Meetings were held bi-monthly and were very well attended. Executive Committee meetings were held one week prior to each regular meeting.

In May, 1949 a dinner meeting was held at The Arlington in Pittsburgh. Following the meeting a discussion was held on the treatment and procedure for tension in the psychoneurotic patient. The discussion was based on excerpts from an article *Occupational Therapy as Psychiatric Treatment* by Dr. Alfred P. Solomon.

The July meeting was devoted entirely to discussion of matters to be voted on at the convention. Information was tabulated from questionnaires which had been sent out in advance to every member. The response was a gratifying indication of the new in-

terest in the organization. At the next meeting, in September, Miss Wirt, our Delegate, made her report of the convention.

The Western Pennsylvania School for the Blind was our host for the November meeting. Miss Clifford, the school's occupational therapist, discussed and demonstrated, with the assistance of a pupil, several techniques in working with the blind.

In January, 1950, a meeting was held at the Pittsburgh Medical Rehabilitation Center to which we invited the district Physical Therapy Association. Dr. Harry Epstein, Director, and Dr. Samuel Sherman, Consultant, discussed the functions of the Center. As an additional treat, the British film *Rehabilitation* was shown, demonstrating the extensive progress being made in this field by Vauxhall Motors, Luton, England.

The final meeting of the year was held at the University of Pittsburgh's newly acquired Western Psychiatric Institute and Clinic. The speaker of the evening was Dr. Harry W. Braun, a member of the Clinic's Research Department. He discussed the animal research program at the Clinic and the need for general research in the field of psychiatry. The group was then taken to the animal laboratory where a testing demonstration was given.

Miss Marjorie Semeno was appointed Recruitment Representative to cooperate with the national program.

Mrs. Harriett Canterbury, Chairman of the Constitution Committee has been working hard and has brought our Constitution up to date.

SEE YOU IN COLORADO!!!!

NEWLY ELECTED OFFICERS

President—Mrs. Gertrude Sobolewski
Vice President—Miss Ann Kevilus
Secretary—Mr. Donald Maud
Treasurer—Miss Ena Hinton
Delegate—Miss Dorothy Wirt
Alternate Delegate—Mrs. Gertrude Sobolewski

TENNESSEE

Delegate-Reporter, Elizabeth Withers, O.T.R.

Since the Tennessee Occupational Therapy Association is just a year old, a summary of its activities is a history of the organization.

In March of 1949 the therapists in Memphis, feeling that a local association would be stimulating and helpful in promoting occupational therapy in this area, met to discuss the feasibility of organizing. The original group comprised twelve active and three associate members.

A committee was appointed to write a constitution which was completed and sent to the Committee on Credentials of the House of Delegates in May. There was much rejoicing when it was approved and the association admitted to the House of Delegates at the Annual Meeting in Detroit. The Membership Committee has contacted therapists in Tennessee, Mississippi and Arkansas, and the group has grown to eighteen active and four associate members.

Recruitment has been the chief project for the year. The chairman and her committee sent literature to all of the high schools and colleges in Tennessee and talks to several groups have been given.

The members living in the Memphis area voted to hold meetings the third Tuesday of each month in the various occupational therapy departments. Miss Ruth Zieke planned the following stimulating programs which have been well attended:

MARCH and APRIL 1949—Both of these meetings were for the purpose of organization.

MAY 1949—The first of our program meetings was held at Lamar Veteran's Hospital. Miss Lillian Wambolt, the therapist in charge, spoke on *Occupational Therapy in the Treatment of Tuberculosis* and conducted a tour of the shop.

JUNE 1949—A dinner meeting of a purely social nature was held.

JULY 1949—This was a called business meeting for the purpose of making a few necessary revisions in the constitution and instructing the delegate.

SEPTEMBER 1949. The first meeting of the fall season was a barbecue at the home of Mrs. Priscilla Neef. The delegate gave her report and the other members who attended the convention gave interesting accounts of the meetings and the social activities.

OCTOBER 1949. A most interesting program was given at the B'nai B'rith Home for the Aged. Dr. J. S. Goltman, the Medical Director spoke on Geriatrics and Miss Virginia Stockwell, O.T.R., Kennedy Veteran's Hospital, discussed *The Functional Treatment of Tabes Dorsalis, Hemiplegia, Parkinsonism and Multiple Sclerosis.*

NOVEMBER 1949—Miss Constance Budlong, O.T.R. and Miss Gayle Baize, O.T.R., both of Kennedy Veteran's Hospital, presented new craft ideas. Miss Budlong showed new and adapted projects, indicating the type of patient for whom it was planned; and Miss Baize demonstrated and taught a new and effective type of stenciling.

JANUARY 1950—Dr. H. White, chief of Clinical Psychology, Kennedy Veteran's Hospital, presented a program of psychological testing. After his discussion, he had the group participate in a type of personality test, which proved most interesting.

FEBRUARY 1950—Miss Lillian Wambolt, O.T.R., Lamar Veteran's Hospital gave a demonstration of and instruction in copper tooling.

MARCH 1950—The movie *Time Out,* an instructive film showing occupational therapy in the treatment of tuberculosis, was shown.

We plan during the coming year to continue our

interesting programs, bringing in all the types of occupational therapy represented in Memphis. And, we hope in the future to help the growth of the profession in the South.

OFFICERS

President—Miss Elizabeth Withers
Vice-President—Miss Ruth Zieke
Secretary—Lt. Lois B. Janssen
Treasurer—Mrs. Sophia Moll
Delegate—Miss Elizabeth Withers
Alternate Delegate—Miss Ruth Zieke

Convention News

Pre-Convention:
October 13-16, 1950

Main Convention:
October 17-19, 1950

Institute:
October 20-21, 1950

Our 1950 convention at Glenwood Springs, Colorado will be streamlined to meet the latest demands that occupational therapists are confronting in our ever-expanding profession. Prominent doctors will appear on the program bringing to us not only the most recent medical developments, but also the application of occupational therapy to their fields of specialization.

The occupational therapy departments of hospitals in and around Denver are looking forward to having you visit them either before or after convention. In the field of tuberculosis, there are several sanitoria in our area with well-developed occupational therapy programs—Swedish National Sanitorium, Craig Colony, Lutheran Sanitorium, National Jewish Hospital, J.C.R.S. (Jewish Consumptive Relief Society), and Fitzsimmons Army Hospital, where the general hospital is carrying on a research program in the latest treatment of tuberculosis.

Goodwill Industries of Denver, in conjunction with their sheltered work shop program, opened a Rehabilitation Center which serves not only Denver but the State of Colorado and other states in the Rocky Mountain Area.

Sewell House in Denver is the headquarters for the Colorado Society for Crippled Children and Adults. A well-coordinated program for occupational therapy, physical therapy, and speech therapy is offered for the handicapped individual. Cerebral palsy cases are treated not only at Sewell House, but also at Children's Hospital in Denver, one of the most modern hospitals of its kind in the country. Recently another cerebral palsy program has been organized in Colorado Springs.

Fort Logan Veterans Administration Hospital is a short distance from Denver City limits. The occupational therapy department directs an extensive general program.

In the field of physical disabilities, the University of Colorado Medical Center and Denver General Hospital have therapeutic work shops under the direction of Dr. Harold Dinken, Chief Physiatrist. These two programs are a part of the Physical Medicine and Rehabilitation Departments.

For those interested in the psychiatric field, Colorado State Hospital at Pueblo and Colorado Springs Psychopathic Hospital are within easy reach of the Denver area. Fitzsimmons General Hospital has an extensive psychiatric program.

Also in Colorado Springs is Halfway House, a curative work shop serving the local hospitals.

We urge you once again to spend a few extra days with us. Many of the above-mentioned hospitals are located in cities leading to some of Colorado's colorful vacation lands— so it is easy to combine business and pleasure. Denver is the gateway to the splendour of the Rockies. Scenic highways lead to Mount Evans, 14,260 feet above sea level, to Pike's Peak, one of the nation's foremost peaks, and to Trail Ridge Road through Rocky Mountain National Park, winding across the Continental Divide, from 11,000 to 12,183 feet in altitude.

In a visit to Pike's Peak, the trip is made via Colorado Springs, just fifteen minutes from Pike's Peak region. This city is the home of the celebrated Broadmoor Hotel, and is within a few miles of some of Colorado's well-known beauty sights. The Broadmoor —Cheyenne Mountain Highway is one of the most spectacular of its kind. The Garden of the Gods, a a breathtaking sight of natural rock formation, frames beautiful Pike's Peak in the distance. Pike's Peak is an important landmark of the early West, for it was this snow-capped peak that guided the early wagon trains. It has been ascended by more people than any mountain in America. Manitou, six miles west of Colorado Springs, contains several medicinal springs and is overshadowed by Mt. Manitou. It is reported that the Indians came to this small city to heal themselves in the waters. We also hope you will have time to travel over historic Ute Pass where Indians rode to their summer hunting grounds.

Rocky Mountain National Park holds for the tourist some of the most breathtaking and magnificent scenery of the Rockies. Its many lakes, streams, rugged peaks and glaciers defy description. From the fertile valleys to the barren areas above the timberline, this incomparable playground has been the subject of many a painter's brush.

Rocky Mountain National Park surrounds Estes

Park, a mountain village catering to vacationists who converge on its many lodges to enjoy Western hospitality and sports. The western gateway to Rocky Mountain Park is Grand Lake, linked to Estes by a motor road across the Divide. One of the largest bodies of water in the State, Grand Lake has the highest yacht anchorage in the world, and many mountains rise from its shores.

Add to this perfect vacationland a worthwhile convention program and it equals a "bang-up" time for all of you. We are looking forward to your visit in October. Don't disappoint us. Watch the next issue for full program details and names of guests speakers. Then we know you will be as happy with the program as we are now! We have surprises in store for you with the list of our speakers coming to participate in your annual convention. Let's all give them a grand reception!

The Colorado O.T. Association

Semantic Reaction

(*Continued from page* 105)

toward him. Both are evident within the individual. Both must be dealt with on the clinical level. The clinician must recognize that the real objective of clinical treatment is the happiness and security of the individual involved. It is obvious that physical improvement is necessary in achieving progress in this area. It should be equally obvious that, only if the person who has cerebral palsy is taught to evaluate the problems of life in proper perspective, can he achieve the personal integration which will lead to real happiness and success as a mature citizen of the community.

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Mr. Berger is librarian in charge of the technical library of the Institute of Logopedics. Miss Giden is research assistant to the director. Both writers are handicapped by cerebral palsy.

Rehabilitation of the Crippled Child

(*Continued from page* 99)

activities should have frequent conferences with the physicians as well as conferences amongst themselves, discussing the merits and demerits of each child in their programs.

At the conclusion of this stage of rehabilitation there should be a conference of the physicians, nurses, therapists, teachers, vocational rehabilitation workers, social workers, and others who have been responsible for the activities and studies of this child. Out of this conference should come a final plan of socialization. Unless each person, who has been responsible for the care, education and study of the child during his physical and mental development, discusses his particular problems with the others, it is not possible to obtain, or even expect to obtain the best possible plan for the return of this child to society.

This final plan of socialization should include a program for economic and social adjustment. Economic adjustment means intelligent job placement, leading to complete financial independence. The handicapped child who may now be in young adult years should be placed in the job for which he has been trained or for which his group of advisors and teachers think he is best suited, because of personality, vocational abilities and skill. The plan for social adjustment will depend on his family and community. Each family and community are different; they should be studied and a plan evolved to enable him to fit into the local situation with as little confusion and friction and emotional disturbance as possible. In this instance the social worker and the psychologist can be of tremendous help. If this economic and social adjustment is successful, there will then result an independent, self-supporting and self-respecting young citizen who "will have no fear and ask no favor from any man", and the rehabilitation of this crippled child will be completed with the job well done.

This plan for rehabilitation is not idealistic, it is extremely realistic. It is an overall approach and can be accomplished in every community and state when proper thought and direction is given to the program by the physicians and *those others* in authority.

*Presented at the Meeting of the Physical Medicine Section of the American Medical Association, Atlantic City, New Jersey, 1949.

Book Reviews

THE FIELD OF SOCIAL WORK

Revised Edition: by Arthur E. Fink
Published by Henry Holt and Co., 1949
577 pages $3.75
Reviewed by: Wanda Misbach Edgerton

The author's purpose is to introduce the field of social work to the beginning student or worker by tracing the development of social work in the various areas of public welfare, private and voluntary agencies, services for families, children and schools, psychiatric, medical and correctional social work, and group work. The last two chapters are given over to community organization for social welfare, and to a look at social work as a profession. This chapter includes a discussion of curriculum requirements in training, The American Association of Social Workers and other professional membership organizations, jobs, salaries and publications.

This should prove a valuable reference for the student who is considering social work as a career. For the occupational therapist, either student or professional, it is recommended as an interesting, easy to read explanation of what goes on in an allied field and should help the therapist cooperate more intelligently with the social worker.

KEEPING IDLE HANDS BUSY

Occupational Therapy
Marion R. Spear, O.T.R.
Burgess Publishing Co.
426 South Sixth Street, Minneapolis, Minn.
Reviewed by: Wanda Misbach Edgerton, O.T.R.

The author has assembled some ninety-six pages of suggestions for things that can be made of waste or discarded cloth, paper or wood, and native berries, shells, seed pods or cones. This is intended primarily as a source book and for this reason specific directions have been omitted.

It is intended for use by housewives, mothers, teachers and camp counselors as well as occupational therapists. Camp leaders, especially, should find the chapter on *Native Products* interesting.

The title of the book seems to this reviewer a most unfortunate one. *A Thousand Things To Do With Scraps,* or something similar, would have been descriptive of its contents at the same time avoiding the unhappy inference that occupational therapy is just *Keeping Idle Hands Busy.*

AMERICAN QUILTS AND COVERLETS

Florence Peto
Published by Chanticleer Press, Inc., 1949
64 pages $2.95
Reviewed by: Wanda Misbach Edgerton, O.T.R.

A beautiful book, beautifully illustrated. It opens with a discussion of historical quilts and coverlets from 1748 to 1948. The second part of the book is given over to instructions on how to plan, cut and piece a quilt, how to make the basic patterns and borders, and how to quilt and bind the finished work.

Aside from the full page plates, many of them in color, there is a generous sprinkling of small black and white drawings throughout the pages. These are illustrations of named quilt block patterns which would be helpful in identifying old quilts that may have lost their identity in being passed from one generation to the next.

If the actual construction of an entire quilt is not adapted to your shop or patients, don't conclude blithely that there is nothing here for you. The presence of a stimulating little book, such as this, might well lead to a full fledged out-of-hospital-back-at-home-hobby for the person who in hospital did nothing more than make blocks of colored paper, with crayon on squared paper, or stitch one block for a hot pad or chair cushion during a convalescence. These old patterns are readily adaptable to other media also, such as hooking, stenciling or block printing.

OCCUPATIONAL THERAPY—PRINCIPLES AND PRACTICE

Edited by William Rush Dunton, Jr., M. D.
Founder and Former Editor of Occupational Therapy and Rehabilitation
and
Sidney Licht, M. D.
Editor, Occupational Therapy and Rehabilitation
Charles C. Thomas, Publisher
Springfield, Illinois
Reviewed by: *Isabel M. Kellogg*

A quote from the forward is as follows "It is believed that in these pages the physician will find specific directions for the application of occupational therapy. However, if he will acquire but a knowledge of its principles he may safely entrust the application of occupational treatment to his therapist, just as he entrusts many nursing procedures to his nurse."

This volume is made up of sections written by physicians and therapists who are specialists in their various fields, and have proved themselves in their application of occupational therapy.

The text includes chapters on the history, principles, prescription, occupational therapy for psychiatric disorders, kinetic occupational therapy, occupational therapy for amputees, occupational capacity and therapy in heart disease, occupational therapy in tuberculosis, occupational therapy in the treatment of cerebral palsy, education for hospitalized patients, bibliotherapy in neuropsychiatry, recreational therapy and drama therapy.

It is interesting to note in the chapter on prescription that it is recommended that the form of exercise or media used be left to the therapist, and that the physician note only the results desired. There is much of value and interest in this book and many analyses of activities and motions. There are suggestions for adjustments to equipment and positions for operation.

Although this book is written primarily for physicians seeking information on the subject, it would be worth your time and effort to find a copy and read carefully each section.

PRINCIPLES AND PRACTICE OF THERAPEUTIC EXERCISES

Hans Kraus, M. D.
Assistant Clinical Professor of Rehabilitation and Physical Medicine New York University College of Medicine. Physician-in-charge of Therapeutic Exercise, Institute of Rehabilitation and Physical Medicine.
New York University—Bellevue Medical Center
Charles C. Thomas, Publisher
Springfield, Illinois, $6.50
Reviewed by: Isabel M. Kellogg

Dr. Howard A. Rusk in the forward says "Rather than develop a long list of exercises 'to be done in the following manner' as is too frequently done in books on exercise, the book is devoted to fundamental knowledge of exercise therapy and the practical application of such knowledge to specific conditions." The author gives both the "Why and How" of therapeutic exercise in musculo-skeletal conditions, the nervous system and in respiration concluding with a part on general exercises.

TROPICAL FISH

Lucile Quarry Mann
Sentinel Books
112 East 19th Street, New York
Revised with additions, 1947
Reviewed by: Isabel M. Kellogg

"Does algae make your aquarium unsightly in your otherwise spick and span treatment center?" Don't let it bother you for the fish are happier in their "green water".

This is an entertaining and informative little volume which deals with the selection of the home for the fish, its furnishing and care and treatment. Interesting descriptions of the various types of fish, their habits and peculiari-

ties are given. Included are excellent lists of common aquarium fish, plants and books concerning fish.

It is a volume one could recommend easily to anyone interested in starting a fascinating hobby. "The advantage of fish as pets is manifold; they are clean, they require little attention beyond a pinch of food, they make no noise, they do not bite strangers, and they never stray away from home."

CREATIVE HANDICRAFTS

By Mable Raegh Hutchins

Sentinel Books Publishers, Inc.
112 East 19 Street, New York, N. Y.
Cloth bound $1.20 Bristol 60 cents

Reviewed by: Wanda Misbach Edgerton, O.T.R.

In one hunderd twenty five pages one cannot expect to find design, pottery, weaving, basketry, leather, bookbinding, block printing, dyeing, rugs, quilting and wood carving covered very adequately. The trained therapist will find nothing new here and students would do better to direct attention to less generalized treatment of these subjects.

However, if you are looking for a little book to put on your shop shelf where patients could pick it up and discover for themselves a variety of possible activities and interests, this might be it. It could also be of use for homebound patients.

THE AMERICAN SQUARE DANCE

Calls and Music With Illustrated Description of Figures for Folk and Country Dances

By Margot Mayo

Sentinel Books Publishers, Inc.
New York, N. Y.
Cloth bound $1.20 Bristol 60 cents

Reviewed by: Wanda Misbach Edgerton, O.T.R.

A concise little book of one hundred pages with a glossary of square dance terms clearly illustrated. This is followed by calls and directions for square sets, quadrilles, longway sets, running sets and play party games. Appropriate music is included, plus a list of records and some helpful hints on how to utilize recorded calls and music. A five page bibliography lists additional resources if you want still further help.

MENTAL HYGIENE IN PUBLIC HEALTH

By Paul V. Lemkau, M.D.

McGraw Hill Series in Health Science
1949 — 396 pages — $4.50

Reviewed by: Wanda Misbach Edgerton, O.T.R.

Dr. Lemkau divides his book into two parts. Part 1 defines the fields of mental hygiene and public health, discusses mental hygiene as a public health responsibility and outlines public health practices in relation to mental hygiene. Part two, the larger part of the book, discusses with clarity and simplicity the fascinating and oftimes complicated business of personality development and maturation. He begins with the prenatal stage and follows the development on through infancy, childhood, adolescence and adulthood to old age.

It is this section in particular which is commended to the student, or to the practicing therapist, as a reference not only valuable but interesting. Prevention is the primary theme and therapy the secondary. To this end there are numerous suggestions for building the personality in the direction of better mental health. Case histories are frequent and each chapter bears a summarizing paragraph at its close.

A forty page review of psychopathological states has been added as an appendix. There is also a list of films which demonstrate good public health practices or the various aspects of the building of personality structure.

ABSTRACTS

Prepared by: Margaret Finnegan

PSYCHIATRIC QUARTERLY SUPPLEMENT

Vol. 23—Part 2—1949

Occupational Therapy With Maximum Security Patients: An Adjunct to Group Psychotherapy

Arvilla D. Merrill O.T.R.

A 19-page treatise, telling of the program of occupational therapy in close alliance with group psychotherapy, as it exists in the maximum security division of St. Elizabeth's Hospital, Washington, D. C.

These patients are all prisoners, who because of their underlying psychotic conditions, were found to be in need of hospitalization.

The author concludes her paper:

"What is the future of occupational therapy with maximum security patients and its relation to group psychotherapy? Occupational therapy can provide a variety of graded, worthwhile purposeful activities, limited only by the patient's ability to accept them. Observations of the patient's reaction to these activities and frequent conferences with the occupational therapist concerning the planned program will assist both the psychotherapist and the occupational therapist in evaluating and making necessary revisions whenever indicated. This total concept of treatment procedures will help the patients toward better understanding of their problems of readjustment not only in the hospital but in the community. It is one method of forestalling chronicity, an insidious thing which attaches itself to idleness. And last, but by no means least, it will provide a greater opportunity for all occupational therapists to understand and assist each other in their efforts toward broadening the scope of the entire treatment program."

THE JOURNAL OF NERVOUS AND MENTAL DISORDERS

April, 1950

Psychological Observations On "Doodling" In Neurotics

J. G. Auerbach, M. D.

Presents observations and explanations of the doodlings drawn by neurotics during a course of analysis. The author presents the aim of his work as follows: to inhibit rather than stimulate any concentration by the subject on his creative work. In this way, the resulting expressions are exclusively unconscious or preconscious presentations of his inner life. This technique was specifically designed to make any deliberateness in the drawings difficult, if not impossible. Ten pages of "doodlings" are then presented—and discussed in detail.

THE AMERICAN JOURNAL OF PSYCHIATRY

April 1950

A *Practical Treatment Program For A Mental Hospital "Back" Ward*

M. G. Martin, M. D.

This paper tells what was done on a so-called "back" ward of one mental hospital. The work described was done on one ward with 72 male patients, 8 attendants, 1 supervisor, and 1 physician. Emphasis was placed on proper staff education and orientation to the program—with favorable results.

Recreational activities, walks, gardening and movies, were all included in the program. The limited concept of occupational therapy was expressed as follows:

"Occupational Therapy did not work out. We tried having the patients rip up burlap bags and tie the strings together. The impression was that other activities were more timeworthy."

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

April 30, 1949
Physical Treatment of the Hemiplegic Patient in General Practice
Harold Dinken, M. D.

States that much can be done to help restore hemiplegic patients to independence and usefulness. However, an objective method of evaluating disability and progress of the patient is necessary. Early therapy, adapted to the individual needs of the case, is also of great importance.

Prognosis in hemiplegia is dependent on the nature, size, and location of the cerebral lesion, and is adversely affected by emotional disturbances or lack of motivation.

Functional capacity is usually slower in returning than motor, and is generally more complete in the leg than in the arm. The general aims of physical treatment are to improve motor function, increase functional capacity, prevent or correct deformity, and to re-adjust the hemiplegic patient to the demands of daily life.

O. T. is listed as one of the effective treatment media, and is subdivided as follows:

1. diversional activities for morale
2. functional activities for fine co-ordination of fingers
3. pre-vocational activities

POSTGRADUATE MEDICINE

January, 1950
Hearing Aids: Procedures for Testing and Selection
William G. Hardy, M. D.

This author reminds us, at the onset, that hearing aids are not a universal solution to all hearing problems. Also, for satisfaction, they are dependent upon proper selection, proper adjustment, and proper training of the individual. Experience has shown, however, that (1) the great majority of persons with impaired hearing have some useful residual hearing, and (2) with a carefully selected appliance, an individual can usually learn to compensate, at least to a fair degree, for his handicap.

Material on hearing aids, diagnostic groups, and diagnosis is presented in detail.

A course in auditory training is discussed next, the objectives of which are:

1. to condition the patient to amplified sound
2. to instruct him in the use of his aid in various situations
3. to give a foundation for the understanding of functional hearing
4. to consider problems of social and vocational adjustment

In presenting this course, a certain amount of group work, especially among the recently deafened, was found beneficial.

THE JOURNAL OF NERVOUS AND MENTAL DISEASE

February, 1950
Group Psychotherapy With Aphasics
Nathan Blackman, M. D.

Presents a group psychotherapeutic program as an integral component in the intensive rehabilitative approach to the problem of aphasia. Among some of the more outstanding benefits to the aphasic patient are the following:

1. The aphasic loses his feeling of being isolated, carrying a set-back or disability greater than any other human has to carry through life.
2. It gives the individual patient a feeling of successful, friendly competitiveness, of comparing both symptoms and aspirations in the presence of a benevolent parent substitute.
3. It reaffirms his social acceptance, at least in terms of the group involved.
4. It lessens his need for dependency on the parental figures and, as a corollary, for dependency on government benefits.

Opportunities for increased socialization were included in the program: and O.T. entered the program at this point. A good picture of the emotional problems accompanying aphasia is given, and several case histories are summarized.

THE MILITARY SURGEON

December, 1949
Preventive Medicine and Rehabilitation
Charles D. Shields, M. D.

This article, written from the public health point of view, points out the close correlation between preventive medicine and the rehabilitation phase of physical medicine. "... even though they meet at extremes, the effort of one to prevent disease and injury, the effort of the other to rehabilitate those who have been its victims."

The importance of official health agencies adding rehabilitation services to their already existing programs is stressed. Some of the findings of the Baruch Committee on Physical Medicine are presented; wherein it is reported that there are approximately 23,000,000 handicapped persons in the United States, and that about 97% of these can be rehabilitated to a point at which they can obtain gainful employment. It states that "rehabilitation fills the gap between the customary end point of medical care and the real necessities of most patients."

HYGEIA

December 1949 (Part 1)
January 1950 (Part 2)
Musicians in White
Doris Paul

A survey of the many aspects of music therapy, written for the non-professional reader. Music in correlation with every field of medicine is touched upon; and many specific examples are given, usually based on work being done in the middle west. Interesting material to read — might prove a good reference for students.

AMERICAN JOURNAL OF PSYCHIATRY

Volume 106 — No. 7 — January 1950
Review of Psychiatric Progress in 1949

Covers all phases of psychiatry, and related fields. The section on occupational therapy is written by Lawrence F. Woolley, M.D. He stresses the world-wide expansion of O.T. in general — and then continues with a concise review of advancements in the field of psychiatric O.T. Though brief, this report includes an extensive biography.

JOURNAL OF THE AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION AND RECREATION

Volume 20 — No. 5 — May 1949
Water Safety for the Physically Handicapped
Ruth S. Ferguson

An account, by a teacher, of a swimming project carried out last summer for children with TB of the bone. This activity was not considered hydrotherapy, but rather a combination of recreation and exercise. Several specific cases are cited.

JOURNAL OF THE AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION, AND RECREATION

Volume 20 — No. 8 — October 1949
Is Recreation a Profession (Editorial)

Points out the importance of recreation in the modern world, and the large responsibility of recreation leaders. Describes a clear-cut pattern, based on eleven good points, to be followed in establishing recreational leaders as a professional group — based on the general criteria for any professional group. Concludes that the recreational field must erect a structure of concept and content before it can rightfully claim membership in the family of recognized professions.

ARCHIVES OF PHYSICAL MEDICINE

Volume 31 — No. 1 — January 1950

What Every Physician Should Know About the Hospital Practice of Physical Medicine and Rehabilitation

W. D. Paul, M.D.

Outlines the diverse functions of a progressive department of Physical Medicine — and the importance of such a department in the hospital. The author states, "For a time Physical Medicine became synonymous with the use of all types of apparatus . . . departments of Physical Medicine were graded not on results obtained but on number and types of machines used." Then the versatility of the present type program is stressed, with the general conclusion that — "the hospital practice of Physical Medicine is no different from the hospital practice of any other specialty."

Special Announcements

ANNOUNCEMENT OF STUDY OPPORTUNITY

Los Angeles County General Hospital

Attention is invited to the following opportunity for advanced or additional study at the Los Angeles County General Hospital. The Players of the Flower Guild are offering $1,500 to be used over twelve months by a registered occupational therapist.

Alternate or combined arrangements may be made to suit the individual. Therefore, please consider the proposal carefully before applying.

Two days of each week will be spent working in the pediatrics section of the Occupational Therapy Department at the Los Angeles County General Hospital. The remaining three days each week will be spent in study or research in any field of occupational therapy in the County Hospital or in one of the nearby universities.

Particular attention is invited to the program at the University of Southern California which offers a masters degree in occupational therapy. A masters degree may be secured in the twelve month period, but it is not recommended because the University is several miles from the hospital. The applicant who has some credit toward her masters degree, or who wishes to complete it at a later time, may take selected courses at the University and this is a practical and stimulating arrangement. For work toward a masters degree, the credentials of the applicant must be acceptable to the University.

Registered occupational therapists who desire to do research or specialized study in a particular field without any University affiliation may do so at the Los Angeles County Hospital under medical supervision. The applicant must be capable of independent or self directed study, and must know what particular project he intends to undertake. Possible avenues of study include general medical conditions, dermatology, orthopedics, and general pediatrics. Special study opportunities in psychiatric conditions, tuberculosis and cerebral palsy are not available. The facilities of the occupational therapy department will be made available for use and no demands will be made on the time of the student except for the two days of work mentioned above.

All applicants should apply, indicating their intended avenue of study, to:

Miss Carlotta Welles, O.T.R.
Head Occupational Therapist
Los Angeles County General Hospital
Los Angeles 33, California

Applicants wishing an affiliation at the University of Southern California should send their credentials to:

Miss Margaret S. Rood, O.T.R.
Department of Occupational Therapy
University of Southern California
Los Angeles 7, California

Your interest and inquiry is invited. *Final selection will* be made *June* 15, 1950 and applications must be received before that date. *Since this notice arrived too late for publication in the April issue it would be well for any interested person to wire their application to Miss Welles.*

The Institute of Physical Medicine and Rehabilitation, in cooperation with The National Foundation for Infantile Paralysis, is undertaking to coordinate material to disseminate information on self-help devices. Under the general plan, information on such devices will be gathered by the Institute of Physical Medicine and Rehabilitation, evaluated, standardized, and then distributed to all interested hospitals, clinics, and rehabilitation agencies. In every instance, of course, acknowledgment will be made to the agency or individual submitting the information.

They are seeking your cooperation in this project and hope you will make available any information you have concerning self-help devices and gadgets. After evaluation, a data sheet will be prepared and the Institute will then distribute copies to all participating organizations. In addition to the loose-leaf sheets supplied to the participating agencies, it is planned to have the material eventually made available in book form.

It will facilitate the gathering of the data for this project if you will volunteer information. Forms for use in submitting your material may be obtained from the Research for Self-help Devices, Institute of Physical Medicine and Rehabilitation, 325 East 38th Street, New York, N. Y. An 8″ x 10″ glossy photograph of the device should accompany the data. Wherever practicable, it is also suggested that the device itself should be sent.

A two weeks intensive personal course in Cerebral Palsy is to be given by Dr. M. A. Perlstein at the Cook County Graduate School of Medicine, Chicago, from July 31 to August 12, 1950.

Registration for the course will be by direct application to Mr. James F. Askin, Registrar of the Medical School.

The American Congress of Physical Medicine will hold its twenty-eighth annual scientific and clinical session August 28, 29, 30, 31 and September 1, 1950 inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on the days of August 28, 29, 30, 31 and September 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30 and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

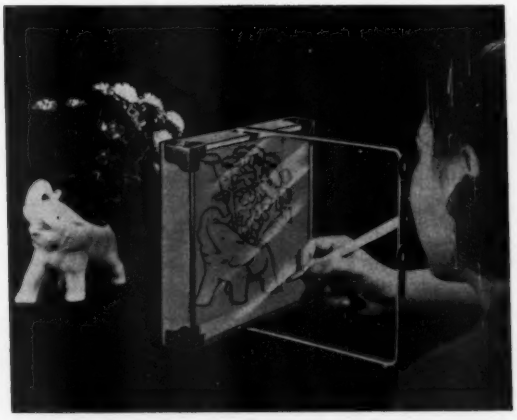
Aphasia
(*Continued from page* 98)

nized in the speech field as one of the most difficult. It requires full professional training, and special experience to be adequate. The experience with returned veterans of this war has increased the amount of possible improvement tremendously, particularly in amnesic types. With this gain in clinical results of course, has also come a gain in clinical complexity.

The difficulties in verbalization, writing, reading, arithmetic and spelling, in addition to being complicated by the above factors, have certain general patterns as well. These are difficulties in stereotype production, difficulties in reception, difficulties in integration, and the so-called amnesic types. The latter may have fairly good comprehension and output but are unable to organize language around specific propositions. A simplified example: A case is able and does say "fountain pen", when shown one, but can only say "that's something you write with", when shown a pencil. When the word "pencil" is said to him, he immediately is able to say it. Drill is absolutely of no value. His whole reaction pattern must be changed. Since this is the most frequent aphasia found in accidents, war injuries, and tumors, it is indeed fortunate that modern technics are extremely effective in the amnesic aphasics. When drill as such is discarded good progress is usually possible.

The problem has so many ramifications that this article has had to be limited to general considerations. Perhaps, however, knowledge of the basic concepts will be of some help to the occupational therapist who must assist in the re-educational process.

HAVE YOU TRIED?



LIN-O-SITE is a drawing device that enables anyone to produce accurate outline pictures of any object. This clever apparatus consists of a wooden frame 8″x9″x1½″, glassed over by a crystal-clear shatterproof plastic sheet. In the center of the frame and secured to the sides is a moveable aluminum viewing arm which may be swung right or left in a semi-circle. When at right angles to the wooden frame, the viewing arm extends forward 8½″. Two peep-sights placed vertically along the front bar of the viewing arm permit seeing the object to be drawn at different levels, while swinging the arm right or left offers views from any angle. The set also includes a special pencil and a pad of tracing paper.

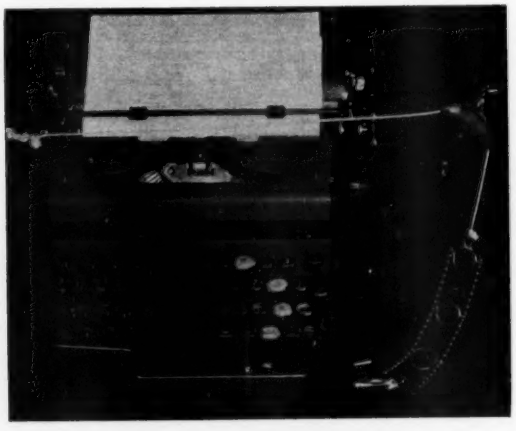
In use, LIN-O-SITE is placed on a table, desk or flat surface and the object to be drawn is set in front of the frame. The viewing arm is then swung forward and the object examined through one of the peep-sights. Bringing the object closer to the frame produces a larger drawing. The outline may fill the frame or any part thereof, as desired.

After the best pose and angle have been decided upon, the special pencil is then used for drawing the outline of the object onto the plastic window. It is actually amazing how easily the most intricate subjects may thus be sketched with accuracy.

When the picture is completed, a sheet of tracing paper is placed over the plastic window, securing the paper by means of tucking the corners under four metal holders. The picture is then traced onto the paper. After removing, the sketch may be shaded further or colored. To erase the drawing from the window, simply wipe with Kleenex or other soft tissue.

Occupational therapists will find the device a quick means of making new applied designs, clever illustrations for hospital publication or a correct perspective for fine arts projects.

The retail price, including frame, pencil and tracing pad is only $2.95 postpaid. Write the Journal office for further information.



Now a one-hand typewriter has been devised that will greatly aid all occupational therapists who must teach people to type with one hand. Think of the aid this typewriter will be to those persons who have lost the use of a writing hand!

This new typewriter has a scientifically designed

(*Continued on page* 144)

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A.J.O.T. CONTEST

The American Journal of Occupational Therapy is offering a prize for the best thesis written by occupational therapy students receiving their occupational therapy certificate during the year 1950.

The article may be on any phase of occupational therapy and should be between 5000 and 8000 words. If a thesis is required for graduation, a copy of this thesis may be submitted if this meets with the approval of the school officials.

The winning thesis will be announced in the October issue and published in the December issue of the Journal.

All entries must be accompanied by a title page which also contains the name, address, school and date of graduation of the applicant. No name must appear in the manuscript proper. All entries must be postmarked on or before midnight July 1, 1950. Address entries:

Manuscript Contest
American Journal of Occupational Therapy
1313 East Elmdale Court
Milwaukee 11, Wisconsin

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 *for* 3 *lines; each additional word ten cents.* (*Average* 56 *spaces per line*). *Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

WANTED: Registered occupational therapist with teaching experience to teach and supervise occupational therapy and recreation aids in schools for in-service training. Write: Personnel Office, Department of Public Welfare, 160 North LaSalle Street, Chicago, Illinois.

Positions open for registered occupational therapists at 1200-bed mental hospital centrally located on eastern seaboard, within two hours by rail of New York and Washington. A broad flexible psychiatric program offers maximum opportunity for initiative. Starting salary for inexperienced workers $2640.00, for experienced $2880.00, maintenance optional. Positions also open for specialists in various activities, supervisors and assistant director. Apply to Elizabeth Ridgway, O. T. Director, Delaware State Hospital, Farnhurst, Delaware.

New Geriatric Research Hospital needs a registered occupational therapist with supervisory experience to organize and develop an occupational therapy program. Also registered occupational therapists wanted for regular positions. Opportunity for qualified persons. Write: Personnel Office, Department of Public Welfare, 160 North LaSalle Street, Chicago, Illinois.

O.T.R. for centrally located 435-bed general hospital associated with medical school of State of Maryland. In-patient program including pediatric service; some functional. Salary $2,000 plus meals and uniform laundry. Paid vacations, sick leave, pension. Apply to Lora E. Denetz, O.T.R., Director, University Hospital, Baltimore 1, Maryland.

Illinois needs registered occupational therapist in State mental hospitals. Positions are available for beginning therapists and supervisors. Civil Service, good salaries, annual vacation, holidays, excellent sickness and retirement provisions. Maintenance if desired. Write: Personnel Office, Department of Public Welfare, Springfield, Illinois.

OCCUPATIONAL THERAPISTS URGENTLY NEEDED in California Departments of Public Health and Mental Hygiene. Work with Adults and Physically Handicapped Children. Immediate Appointments at starting monthly salaries of $243, 268, and 295. Examination later for Permanent Civil Service Status. Write today to Recruitment Representative Dept. 0-1, State Personnel Board, Sacramento 14, Calif.

Four openings for O.T.R.'s. Starting salary $243, or $295 with 1 yr. experience. In Valley of the Moon, 50 miles north of San Francisco. Write Sonoma State Home, Eldridge, California.

OCCUPATIONAL THERAPISTS for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food. Maintenance optional. Liberal retirement plan and illness policy. Paid vacations and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Connecticut.

Occupational therapist for forty-nine bed Children's Convalescent Hospital in Southern California. Good salary, part maintenance, paid vacation and holidays, forty hour week. 850 South 36th Street, San Diego 13, California.

Occupational Therapists wanted for large psychiatric hospital in Connecticut. Student training affiliations. Maintenance optional, paid vacation and holidays, retirement and insurance plan. Address Doctor Edgar C. Yerbury, Superintendent, Connecticut State Hospital, Middletown, Connecticut.

Qualified occupational and recreational therapist, small state mental hospital, Southwest. Salary after three months probation, $2400.00 per year, plus full maintenance, Box 244, American Journal of Occupational Therapy.

Immediate openings in Maryland's mental, tuberculosis, and chronic disease hospitals for occupational therapists. Position requires completion of high school; completion of courses in an accredited school of occupational therapy; plus registration or eligibility for registration by the American Occupational Therapy Association. The salary scale for the mental hospital positions is $2517-3147. For the tuberculosis and chronic disease hospitals the salary scale is $2000-2500. Merit system positions insuring security of employment, automatic salary increases, liberal vacation and sick leave plus retirement benefits. Mail inquiry to State Employment Commissioner, 31 Light Street, Baltimore 2, Maryland.

Wanted: Staff therapist — $46 weekly, 4 weeks vacation, sick time. Write Miss Margaret Bishop, O.T.R., The New York Hospital, 525 E. 68th Street, New York 21, N. Y.

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(*Continued from page* 140)

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CORRECTION

Cerebral Palsy Issue, Vol. IV, No. 2, page 66. The fifth paragraph should be corrected to read:

Printed with this article is a copy of an achievement record which has been devised and used successfully with school age children ranging from 5 to 17 years of age with all types and degrees of severity of cerebral palsy. The chart is so arranged that the "test" or recording can be repeated three times in order to show progress. The interval of time between tests and the length of time for one complete recording covering all charted items is, of course, at the discretion of the occupational therapist. However, patients anxious to do as well as possible like to practice before being graded on their proficiency. Three weeks to one month to complete the record would seem reasonable, and the repetition of the test in six months to one year would depend upon such factors as number of treatments per week, regularity of attendance, and severity of handicap. Parents can be of help at home during the testing periods by not assisting the patient any more than is absolutely necessary, thus allowing the child to achieve and become proficient in normal activities within his abilities.

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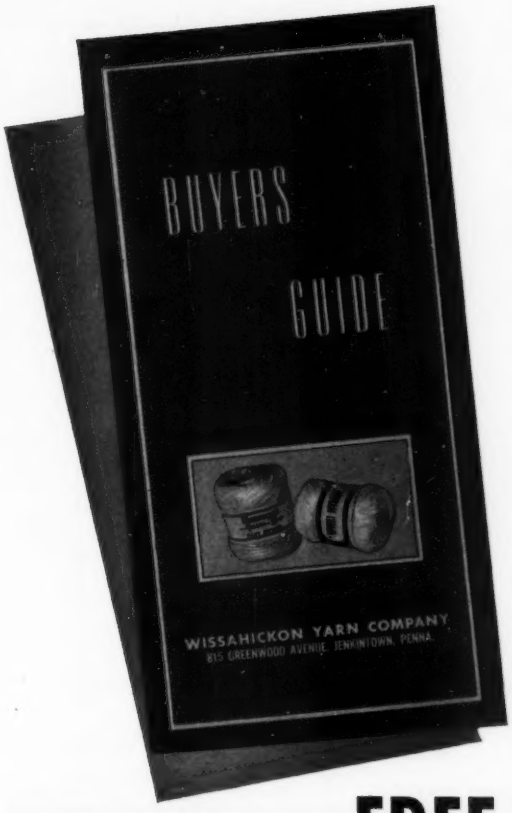

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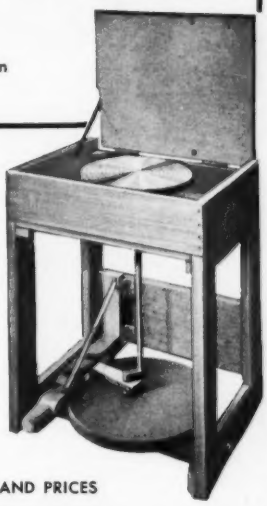

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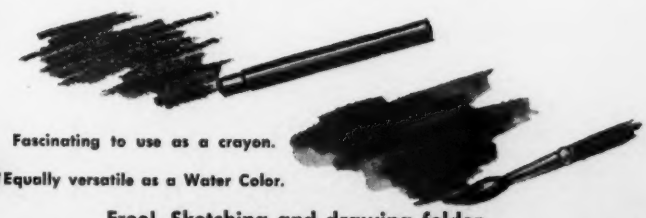

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